STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396009	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norriton Square Nursing and Rehabilitation Center	1700 Pine Street Norristown, PA 19401

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on observations, clinical record review, and interviews with staff and residents, it was determined that the facility failed to provide reasonable accommodations of needs relating to a bariatric bed and a functioning heater for two of 31 residents reviewed.(Residents R251 and R248) Findings include: Review of Resident R251's Minimum Data Set (MDS-federal mandated assessment for all residents) dated February 12, 2025 revealed that Resident R251 was admitted into the facility on [DATE] with diagnosis' including respiratory failure (respiratory system cannot maintain normal levels of oxygen and carbon dioxide in the body), chronic congestive heart failure(long term condition , the heart is unable to pump blood effectively), type 2 diabetes(condition that occurs when blood glucose is too high) and morbid (severe) obesity (health condition that results from abnormally high body mass that is diagnoses by having a body mass index(BMI) greater then 40). Review Resident R251's lift transfer evaluations dated February 6, 2025, revealed Resident R251's weight dated February 6, 2025, was assessed at 316 pounds (lbs) and Resident R251's height as 65 inches. This resident is assessed of not being able to independently turn or reposition in bed or the chair, the resident requires extensive total assistance to turn reposition of two or more staff. Review of facility assessment revealed that equipment and supply inventories this facility currently has adequate equipment to supply all therapies. Medical and non-medical equipment required hospital beds with bariatric capability, and Hoyer lifts with bariatric capability. Observation of Resident 251 on February 9, 2025, at 11:05 am, revealed Resident R251 lying in a regular sized hospital bed. Maintance Director, Employee E11 fixing resident bed by releasing extender to lengthen the bed while resident was still occupying the bed. The bed was observed with extender and regular mattress (too small for bed frame). Interview with resident at time of observation revelaed Resident R251 vocalized discomfort. Interview with Maintance Director, Employee E11 at time of the above observations revealed that he has a new mattress to install but cannot move the resident. Employee E11 was just notified on this day that the residents bed needed adjustment. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further observation of Resident R251 on February 9, 2025, at 11:35 a.m. was observed four staff members assisting in lifting resident from bed with Hoyer lift while Maintance Director, Employee E11, extended the bed frame width and switched the mattress to accommodate for large mattress to fit bariatric bed setting. The resident bed was made to a bariatric setting three days after he was admitted into the facility. Observation of Resident R248 February 10, 2024, at 10:42 a.m. revealed resident sitting in chair with sheet wrapped around her. Further observation revealed cool air coming from heater unit in the resident's room. Interview with resident at time of observation revealed that resident stated she was cold and requested a blanket. Interview with Maintance Director, Employee E11 at time of observation revealed that the heater is supposed to blow cool air temporality, its not broke that is how it works. This employee deferred all other questions to Regional Maintenance Director Employee E12. Interview with Regional Maintance Director, Employee E12 on February 10, 2024, at 11:05a.m. revealed that the heater unit has a safety mechanism that prevents the system form overheating and the cold air will only blow for a short time. During this interview Employee E12 demonstrated that the heater would turn to hot air,. Employee E12 dismantled the heater unit and determined that this unit was not functioning properly. Employee E12 confirmed that the heater unit in Residents R 248's room was not functioning. 28. Pa. Code 201.29(j) Resident rights 28. Pa. code 211.12(d)(1) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on clinical record reviews and interviews with staff, it was determined that the facility failed to follow physician orders related to diabetes management for one of 24 residents reviewed (Resident R24). Findings include: Review of Resident R24's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated January 20, 2025, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including diabetes (ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose). Review of physician orders for Resident R24 revealed an order, dated May 23, 2023, to check the resident's blood glucose level and notify the physician if greater that 400. Review of Resident R24's blood glucose levels revealed the following: On January 24, 2025, at 4:36 p.m. blood glucose level was 416; On January 1, 2025, at 8:32 p.m. blood glucose level was 416; On December 29, 2025, at 4:18 p.m. blood glucose level was 423; On December 27, 2025, at 8:17 a.m. blood glucose level was 427; On December 25, 2025, at 8:29 a.m. blood glucose level was 427; On December 17, 2025, at 4:38 p.m. blood glucose level was 416; and On November 15, 2025, at 8:56 p.m. blood glucose level was 407. Review of medication administration records and progress notes for Resident R24 revealed that there was no indication that the physician had been notified of the above blood glucose levels. Interview on February 11, 2025, at 10:53 a.m. Employee E13, unit manager, confirmed the above findings. 28 Pa Code 211.12(d)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on observations, staff interviews, and review of clinical records, it was determined that the facility failed to ensure that weekly weights were obtained for two out of twenty-four residents reviewed with a history of weight loss (Resident R39 and Resident R74). Findings include: Review of Resident R39's clinical record revealed that Resident R39 was admitted to the facility on [DATE]. Review of Resident R31's clinical record revealed the diagnoses of Huntington's Disease (neurogenerative disease), Dysarthria following Non-traumatic Sub-arachnoid Hemorrhage (cranial bleed), Dysphagia (inability/difficulty swallowing). Review of Resident R39's clinical record revealed a physician's order dated August 21, 2023 for the resident to be weight monthly every day shift starting on the 1st and ending on the 5th every month. Review of Resident R39's weight record revealed the following weight values in pounds (lbs.): May 1, 2024 - 150.4 lbs., June 19, 2024 - 135 lbs., July 2024 - no values recorded, August 6, 2024 - 0.0 lbs., September 19, 2024 - 135 lbs., October 30, 2024 - 112.6 lbs., November 1, 2024 - 114 lbs., December 2, 2024 - 132 lbs. (was crossed out), January 2, 2025 - 109 lbs., January 28, 2025 - 112 lbs., January 31, 2025 - 106 lbs., February 2, 2025 - 110 lbs. Further review of Resident R39's weight record revealed that on June 19, 2024, documented weight value was 0.0 pounds, Further review of Resident R39's weight record revealed a notation of Last weight obtained - weights discontinued next to the weight value of 0.0 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident R39's weight record revealed that there was no weight for July 2024. Further review of Resident R39's weight record revealed that on August 6, 2024, Resident R39 refused to be weighed. Review of Resident R39's clinical record revealed no documented evidence that Resident R39 was reweighed or an attempt to reweigh was done. Review of Resident R39's weight record revealed that on December 2, 2024, Resident R39's weight was 132 pounds. Further review of Resident R39's weight record revealed a notation of disputed value next to 132 pounds. Review of Resident R39's clinical record revealed no documented evidence that Resident R39 was reweighed or an attempt to reweigh was done. Interview with Regional Nurse Employee E26 and conducted on February 11, 2025, at 12:35 pm, confirmed that there was no documented evidence that Resident R39 was reweighed in June 2024 and August 2024 after Resident R39 refused to be weighed on June 19, 2024, and August 6, 2024; that there was no weight for July 2024; and that Resident R39 was not reweighed after a disputed weight value in December 2, 2024. Further interview with Employee E26 revealed that if during obtaining weight for a resident, there is a significant weight difference between the weight value obtained and the previous weight value, a re-weight must be done. Further, Employee E26 also revealed that when a resident refuses to be weighed, a re-weigh must be attempted at another time and that the attempts must be documented. Review of Resident R74's clinical record revealed that Resident R74 was admitted to the facility on [DATE]. Review of Resident R74's care plan revealed that Resident R74 was at potential nutritional risk: history of alcohol abuse, trending weight loss with potential for further weight changes due to progressive decline expected from dementia. Review of Nutrition assessment dated [DATE], revealed: Unable to assess weight changes as July weight is missing and August weight is pending. Resident R74's weight record revealed no documented evidence that Resident R74 was weight in July 2024 and May 2024 the following weight values in pounds (lbs.): October 17, 2024 - 217.2 lbs. September 4, 2024 - 216.4 lbs. July 2024 - no weight value documented June 2, 2024 - 236 lbs. May 2024 - no weight value documented April 2, 2024 - 235.2 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Regional Nurse Employee E26 and conducted on February 11, 2025, at 12:35 pm, confirmed that there was no weight for Resident R74 for July 2024 and May 2024. Review of resident R240's Minimum Data Set (MDS a federal mandated assessment for all residents) dated February 1, 2025 revealed resident R 240 was admitted [DATE] with diagnosis' including metabolic encephalopathy (brain dysfunction caused by metabolic imbalance), diabetes (metabolic disease characterized by elevated levels of blood glucose) unspecified protein calorie malnutrition, and spinal stenosis and dysphagia (difficulty swallowing). Review of resident's weights dated August 12, 2024 through present date February 7, 2025 revealed a steady decline of weight totaling a weight loss of 57.8 lbs in six month time. August 12, 2024, resident weight 237 .8lbs. August 21, 2024, resident weight 234.2lbs. a 1.51% weight loss September 19, 2024, resident weight 227.6 lbs. a 2.82% weight loss. October 26, 2024, resident weight 221.8 lbs. a 2.61% weight loss. October 31, 2024, resident weight 215.7 lbs. a 2.75% weight loss. November 1, 2024, resident weight 214.8 lbs. a 42% weight loss. December 30, 2024, resident weight 210.4 lbs. a 2.05% weight loss. January 21, 2025, resident weight 196.6 lbs. a 5.41% weight loss. January 23, 2025 resident weight 193 lbs. a 3.31% weight loss and a 18.84% weight loss over 6 months. February 3, 2025 resident weight 180. lbs. a 7.22% weight loss. Review of residents clinical record revealed that during the month of August 2024 to February 2025 this resident was hospitalized on the following dates: October 19, 2024 through October 23, 2024 October 23, 2024 through October 25, 2024 December 4, 2024 through December 11, 2024 January 16, 2025 through January 21, 2025 Comparison time and weight loss revealed that in the months of August 2024 through September 2024 Resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R240 had a weight loss of 6.6 lbs. prior to hospitalization . Continued comparison revealed that from October 26, 2024 through November 1, 2025 the resident had a 7 lb weight loss after returning from the hospital and again from January 21, 2025 through January 23, 2025 a 3.6 lb weight loss. Review of physician orders dated February 1, 2025 revealed an order for the resident to be weighed every day shift for four weeks. There is no documentation that weights were obtained as ordered by the physician. Further review of physician orders revelaed an order for house supplement dated February 7, 2025 and an order to offer evening snacks also dated Febraury 7, 2025. Review of Resident R240's clinical record revealed multiple nutritional assessments from the time of August 2024 to through February 7, 2025 that revealed Resident R240 was assessed as eating a regular diet double portion most of his meals, appears well nourished, weight loss detected likely due to hospitalization s. Review of Nutritional assessment dated the January 22, 2025 revealed residents weight 196.6 BMI (body mass index) 29 weight loss of 13 pounds * 1 month 25.2 pounds times three months weight loss likely related to recent hospitalization s plan is to encourage PO intakes continue to encourage dietary compliance desirable due to obesity RD (Registered Dietician) will continue to monitor weight intakes labs meds and skin as well as update CP (care plan). Review of resident's care plan revealed resident is it nutritional risk related to trending significant weight loss since October of 2024 multiple recent hospitalization s history of obese BMI created on February 7, 2025 with implement interventions offer HS (evening) snack and house supplement once daily. Review of Registered Dietitian's note dated February 7, 2025 revealed weight change significant weight loss of 58 pounds over six months weight loss related to multiple recent hospitalization s order for meal monitoring times three days recommending adding health supplement every day continue double portions and snack goal is for weight stability without further losses Physician note day of February 4, 2025 resident is seen for new admission post hospitalization on ly notation indicated in this note is denies weight loss fever and chills. Interview with interim Registered Dietician, Employee E5 on February 10, 2025 at 11:00 a.m. revealed that the resident was assessed for significant weight loss but due to frequent hospitalization s. This employee could not determine why the resident continued to lose weight while in the facility post hospitalization s. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12(d)(1)(3) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on observation, review of facility policy and interviews with staff, it was determined that the facility did not maintain respiratory equipment according to professional standards of practice for two of twenty-four residents reviewed. (Resident R17 and Resident R56) Findings: Review of facility policy entitled Oxygen: Concentrator revealed that An Oxygen concentrator extracts oxygen molecules from room air. It can be used for low oxygen flows rates (i.e. 1-4 L/min). #9. Label, date, and attach pre-filled humidifier bottle, if applicable. Review of Resident R17's clinical record revealed that Resident R17 was admitted to the facility on [DATE], with most recent readmission of February 2, 2025. Further review of Resident R17's clinical record revealed the following diagnoses Chronic Diastolic Congestive Heart Failure (excessive body fluid caused by a weakened heart muscle) and Atrial Fibrillation (irregular and rapid heart beat). Review of Resident R17's physician's orders revealed an order for: Oxygen at 2 L/min via Nasal Cannula, continuously. every shift Post Tx: Evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds-dated February 5, 2025. Observation conducted during tour of the 3rd floor unit on February 9, 2024, at 10:30 am revealed that Resident R17 was in bed sleeping. Further observation revealed that Resident R17 was on Oxygen concentrator at 3 liters/minute via nasal cannula. Further observation revealed that the Oxygen tubing did not have a date affixed to it. Interview with licensed nurse Employee E3 conducted at the time of the observation confirmed that Resident R17's oxygen tubing was not dated. Further, Employee E3 revealed that oxygen tubings are changed once a week. Review of resident R56's clinical record revealed that Resident R56 was admitted to the facility on [DATE]. Further review if Resident R56's clinical record revealed that Resident R56 had diagnoses of Chronic Obstructive Pulmonary Disease (disease process that causes decreased ability of the lungs to perform), Chronic respiratory failure . Review of Resident R56's physician's order revealed an order obtained January 7, 2025 for: Oxygen tubing to be changed weekly. Oxygen at 6 L/min via Nasal Cannula, continuously every shift Post T x: Evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds. -ordered 10.22.24 Review of Resident R56's quarterly MDS (minimum data set- a federally required resident assessment conducted at a specific interval) dated November 8, 2024, section O 0110. Special Treatments, Procedures, and Programs, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C1 Oxygen therapy, was coded yes. Observation conducted during tour if the 3rd floor unit on February 9, 2024, at 10:37 am revealed that Resident R56 was in bed sleeping with oxygen concentrator at 6 liters/minute via nasal cannula. Further observation revealed that the humidifier bottle and the oxygen tubing were not dated. Interview with licensed nurse Employee E3 conducted at the time of the observation revealed that oxygen tubings are changed once a week. Further Employee E3 confirmed that Resident R56's humidifier bottle and oxygen tubing were not dated. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(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. 48347 Based on observation, review of facility policies and interview with staff, it was determined that the facility failed to ensure that a medication cart was kept locked when not in use and that medications were properly stored for two of two carts. (Medication Cart A and Medication Cart B) Findings include: Review of facility documentation titled Medication Storage dated January 2025 revealed that medication storage and biologicals are stored properly to support safe effective drug administration. The pharmacy dispenses medication that meets state and federal labeling requirements, medications are to remain in containers and stored in a controlled environment this may include such containers as medication carts, medication rooms, and medication cabinets. Licensed nurses, pharmacy staff and those lawfully authorized to medications are to have access the medication carts. Medication should remain locked with not in the use or attended to by persons with authorized access. The medication supply shall be accessible only to licensed nursing personnel pharmacy personnel or staff members lawfully authorized to administer medication. Observation of medication cart A located in the hall of the second floor on February 9, 2025, at 8:35 a.m. revealed a bottle of over-the-counter medication aspirin set on the top of the cart. The medication cart A was unlocked and unsupervised. Interview with licensed nurse, Employee E7 on February 9, 2025, at 8:39a.m., this employee confirmed that cart was her responsibility, and she left the cart to assist a resident. Observation of medication cart B on February 9, 2025, at 08:49 am during medication pass with licensed nurse, Employee E23 the cart was viewed to have an over-the-counter medication bottle of mucus relief expectorant being used to support the medication cart computer. Interview with Employee E23 at time of observation confirmed that the medication bottle was not an appropriate use to secure the computer. 28 Pa. Code 211.9(a)(1) Pharmacy Services 28 Pa. Code 211.12(d)(5) Nursing Services

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 39344 Based on observations and interviews with residents and staff, it was determined that the facility did not provide foods in accordance with resident preferences for three of 24 residents reviewed (Residents R43, R42 and R19). Findings include: Review of resident R 43's quarterly minimum data set (MDS- a federal mandated assessment of all residents) December 24, 2025, revealed resident r 43 was admitted into the facility August 14, 202 with diagnosis' including coronary artery disease(CAD-Plaque buildup in the hearts arteries), heart failure, anxiety(disorder of episodes of intense anxiety and fear), schizophrenia(mental disorder characterized hallucinations, delusions and disorganized thinking and behavior). Resident 43 requires setup and cleanup assistance for dining. Review of resident R43's physician orders dated October 23, 2024, revealed an order for lacto- ovo vegetarian diet (a diet that excludes meat, poultry, and fish, but allows eggs and dairy products) Review of resident R 43 care plan revealed that resident R 43 is at nutritional risk related to underweight bmi(body mass index-calculated measure of weight relative to height) and has potential for weight fluctuations. Resident R43 is now in hospice therefore has potential for weight loss but focuses comfort care date revised on December 24th, 2024, with interventions including to honor food preferences within meal plan vegetarian, eggs, dairy, and fish. Observation of resident R 43 receiving the lunch tray on February 9, 2025, at 12:25 p.m. revealed that resident R 43 lunch order was to be a vegetarian burger, basil roasted carrots, and seasoned potatoes wedges. The lunch tray delivered to resident 43, consisted of a fish sandwich with a side of mashed potatoes. The above observation was confirmed by medical supply coordinator employee E 22. This employee notified the kitchen of the mistake and ordered the correct lunch. Interview with dietary employee, E5 on February 10, 2024, at 11:35a.m. confirmed the order for resident R 43 was incorrect and was resolved immediately. Interview on February 9, 2025, at 12:49 p.m. revealed Resident R42's family member stated that the resident follows a vegetarian diet and that the facility does not always provide vegetarian foods as requested. Review of Resident R42's care plan, dated April 12, 2019, revealed that the resident was at nutritional risk with interventions including maintain the resident's cultural food preferences, provide vegetarian diet and to honor the resident's food preferences. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on February 9, 2025, at 12:56 p.m. of Resident R42's meal slip revealed that the resident was supposed to receive a vegetarian burger patty, cottage cheese and a vegetable and cheese sandwich on whole wheat bread. Observation of the resident's meal revealed that the resident did not receive any of the above items. Interview on January 9, 2025, at 1:22 p.m. Employee E4, nurse aide, confirmed that the resident did not receive the requested items on his lunch tray. Employee E4, nurse aide, stated that residents often complain that they do not receive menu items as requested. Review of Resident R19's care plan, dated October 4, 2023, revealed that the resident was at nutritional risk, with interventions including maintain the resident's cultural food preferences, provide vegetarian diet and to honor the resident's food preferences. Observation on February 9, 2025, at 1:13 p.m. revealed that Resident R19 received potatoes, carrots, cake and juice for lunch. Review of Resident R19's meal slip revealed that the resident was supposed to receive a vegetarian burger patty with her meal. Interview with Resident R19 confirmed that she did not receive a vegetarian burger patty or any source of protein with her meal. Resident R19 stated that she prefers either the vegetarian burger patty or cheese with her meals. Interview on February 10, 2025, at 12:52 p.m. Employee E6, food service director, revealed that veggie burger patties and cheese were available in the kitchen to serve with meals. Employee E6, food service director, was unable to explain why these items were not served to Residents R42 and R19 and stated that maybe the weekend kitchen staff were not aware of the residents' food preferences. 28 Pa Code 211.6(a) Dietary services 28 Pa Code 211.10(c) Resident care policies

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Norriton Square Nursing and Rehabilitation Center	1700 Pine Street Norristown, PA 19401

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46508 Based on observations, interviews with staff, and a review of facility procedures, it was determined that the facility failed to store food, in accordance with professional standards for food service safety. Findings include: Review of facility Policy entitled Receiving revealed that under Policy Statement: Safe food handling procedures for time and temperature control will be practiced in transportation, delivery and subsequent storage of all food items. Under section Procedures: #5. All food items will be appropriately labelled and dated either through manufacturer packaging or staff notation. #7. All non-perishable foods and supplies will be stored appropriately Observation of the general kitchen area during the tour of the kitchen conducted on February 9, 2025, at 8:59 am revealed two metal shelving units against the wall of the kitchen. Observation of one of the shelving units revealed that the middle shelf of the metal shelving unit had a plastic bin with white powder. Further, the plastic bin was labelled breadcrumbs with label indicating opened 12/19/24 and use by 1.19.25. Interview with dietary staff Employee E29 conducted at the time of the observation revealed that the white powder in the bin labelled breadcrumbs was corn starch and not breadcrumbs. Further observation revealed another plastic bin of white fine grainy white substance was next to the bin labelled breadcrumbs. Further, the bin containing the white fine grainy substance was not labelled. Interview with dietary staff Employee E29 conducted at the time of the observation revealed that the white fine grainy substance in the unlabeled plastic bin was white sugar. Further observation revealed that the bottom shelf of the metal shelving unit revealed another plastic bin containing a white powder. Further the bin containing the white powder was not labeled. Interview with dietary staff Employee E29 conducted at the time of the observation revealed that the white powder in the unlabeled bin at the bottom of the shelf was flour. Observation of the bottom shelf of the second metal shelving unit revealed a plastic bin containing a yellowish course grainy substance. Further the bin containing the yellowish course grainy substance was not labeled. Interview with dietary staff conducted at the time of the observation revealed that the yellowish course grainy substance in the unlabeled bin was panko. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the freezer revealed a metal pan containing mixed pasta covered in saran wrap. Further, the metal pan was not labelled. Observation during refrigerator inspection revealed ten sandwiches wrapped in saran wrap. Further observation revealed that the sandwiched were not labelled. Further observation revealed one loaf of bread in a plastic bag. Further, the loaf of bread was not labelled. Further observation revealed three plates of salad (green leafy vegetables) with a slice ham. Further observation revealed that the three plates of salad (green leafy vegetables) with ham were not labelled. Observation of the dry storage room revealed a plastic bin with cover half filled with cereal. Further observation revealed that the plastic bin containing cereal was not labelled. Further observation revealed uncooked spaghetti wrapped in saran wrap. Further observation revealed that the uncooked spaghetti wrapped in saran wrap was not labelled. Further observation revealed an opened plastic bag of uncooked fettuccini wrapped in saran wrap. Further observation revealed that the opened plastic of uncooked fettuccini wrapped in saran wrap was not labelled. Further observation revealed an opened bag of rice crispies without the box, with the plastic wide open with rice crispies exposed to air. Further observation revealed that the opened bag of rice crispies was not labelled. Further observation revealed an opened bag of cornflakes without the box, with the plastic wide open with cornflakes exposed to air. Further observation revealed that the opened bag of corn flakes was not labelled. Follow-up tour of the kitchen with District Manager Employee E27 and kitchen supervisor Employee E28 conducted on February 9, 2025, at 10:20 am confirmed the above observations 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, review of facility documentation, review of personnel files and interviews with staff, it was determined that the facility failed to ensure that staff were licensed and registered in accordance with State laws for three of 11 personnel files reviewed (Employees E21, E17 and E16). Findings include: Review of facility documentation submitted to the Pennsylvania Department of Health on [DATE], at 4:33 p. m. revealed that on [DATE], the facility discovered that Employee E21, RN (registered nurse), was working with an expired nursing license and that the license had expired on [DATE]. The facility provided education to Employee E21, RN, including its policy that it is the responsibility of the employee to maintain an active nursing license at all times and that if the license is not current that the employee may not work until the license is active. Employee E21, RN, subsequently reactivated her nursing license on [DATE]. In response to the above incident, that facility conducted an audit of all employees with nursing licenses and nurse aide registries. Review of the audit revealed that Employees E17 and E16, nurse aides, were not included on the audit. Review of Employee E17's personnel file revealed that the employee was hired on [DATE], as a nurse aide. Continued review revealed that the employee completed a nurse aide training course on [DATE]. Review of Employee E16's personnel file revealed that the employee was hired on [DATE], as a nurse aide. Continued review revealed that the employee completed a nurse aide training course on [DATE]. Observation on February 9, 2025, revealed that Employee E16, nurse aide, provided care to residents on the second floor nursing unit during the day shift. Review of the Pennsylvania Department of Health requirements for nurse aides, published at https://www.pa.gov/agencies/health/business-registration-and-regulation/nurse-aide.html, revealed, A nurse aide who is not enrolled or in good standing on the registry may not be employed in a nursing care facility that receives Medicare or Medicaid reimbursement. Review of the Pennsylvania nurse aide registry on February 10, 2025, revealed that Employees E17 and E16 were not enrolled on the registry. Interview on February 10, 2025, at 1:37 p.m. the Nursing Home Administrator confirmed that Employee E21, RN, worked with an expired nursing license in November and [DATE]. Continued interview revealed that Employees E17 and E16 were not identified during the facility's audit of licensed and registered nursing staff because the employees were not registered to work as nurse aides in Pennsylvania. 28 Pa Code 201.3 Definitions - Nurse aide (iv) 28 Pa Code 201.3 Definitions - RN registered nurse (continued on next page)

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.19(3) Personnel policies and procedures 28 Pa Code 211.12(d)(1) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48347 Based upon observation, interviews and review of clinical records and facility policy, it was determined the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of multi-drug resistant organism (MDRO) transmission for one of 31 residents reviewed. (Resident R35) Findings include: Review of facility policy titled Enhanced Barrier Precautions revised December 16, 2024, revealed enhanced barrier precautions (EBP) are an infection control intervention designed to reduce the transmission of novel or multidrug resistant organisms. It employs targeted personal protective equipment (PPE) during high contact resident activities. This includes all residents with any other following infection or colonization with targeted MDRO, chronic wounds, indwelling medical devices (eg: central line, urinary catheter, feeding tube, tracheotomy). The use of personal protective equipment (PPE) must be used during high contact patient care activities include dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care. Personal protective equipment should be accessible and located outside the patient's room. Appropriate enhanced barrier precautions (EBP) sign on patient's room door. All staff receive training on enhanced barrier precaution upon higher and as needed, all staff receive training on high-risk activities and organisms that require enhanced barrier precaution. Review of Resident R35's Minimum Data Set (MDS-federal mandated resident assessment) dated January 2, 2025, revealed Resident R35 entered the facility on December 24, 2024 with a diagnosis of Type 2 diabetes (failure of the body to produce insuli). The resident was also assessed as having a diebetic foot ulcer. Review of resident's care plan revealed that this resident required assistant and was dependent for all ADL (activities of daily living) care in bathing, grooming ,personal hygiene, dressing, eating, bed mobility, and transfers related to paralysis and weakness affecting left side. Continued review of resident's care plan revealed this resident is at risk for skin breakdown related to an actual pressure ulcer. Review of resident's clinical record revealed a Kardex (document that provides instructions related to resident's care needs) included code status, activities, preferences, behavior, cognition, and toileting. Further review of the Kardex indicated to monitor for skin breakdown, dressing, grooming and skin care. This document had no indication that Resident R35 was on enhanced barrier precautions. Review of resident's wound care notes revealed resident has an arterial right dorsum first digit wound (right big toe). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Employee E16 providing incontinence care to Resident R35 on February 9, 2025 at 11:00 a. m. revealed that Employee E16 was only wearing gloves,and no gown. Interview with Employee E 16 at time of observation, this employee denied that PPE was required for resident R 35, the enhanced barrier precaution sign on the door was indicated for resident R 35's roommate. The resident occupying the second bed in this room was also ordered enhanced barrier precautions. 28 pa. Code 211.12(d)(1)(5) Nursidneg Services 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 39344 Based on review of personnel records and interviews with staff it was determined that the facility failed to ensure that nurse aides received at least 12 hours of in-service education per year as required for one of six nurse aide personnel files reviewed (Employee E9). Findings include: Review of Employee E9's personnel file revealed that the employee was hired on June 20, 2019, as a nurse aide. Continued review revealed that from February 11, 2024, through February 10, 2025, Employee E9, nurse aide, completed only two courses of annual education: hand hygiene and personal protective equipment. Interview on February 10, 2025, at 12:52 p.m. the Nursing Home Administrator confirmed that Employee E9, nurse aide, had not completed 12 hours of annual in-service education as required. 28 Pa Code 201.19(7) Personnel policies and procedures 28 Pa Code 201.20(a) Staff development