STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396017	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehabilitation Will	3485 Davisville Road Hatboro, PA 19040

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38735 Based on review of facility documentation and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers and discharges as required. Findings include: Documentation of notification to the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers and discharges for the past three months was requested on August 15, 2024, at 12:45 p.m. from Employee E1, Nursing Home Administrator (NHA). Interview with NHA on August 15, 2024, at 1:50 p.m. confirmed that the facility did not send the notification to the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers and discharges for the past three months. She indicated that this function will be done by the new social worker going forward. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management

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

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, review of facility policies, clinical record review and interviews with residents and staff, it was determined that the facility failed to develop a baseline care plan that includes the instructions needed to provide effective and person-centered care within 48 hours of admission for two of four residents reviewed for intravenous therapy (therapy that delivers liquid substances directly into a vein) (Residents R5 and R58). Findings include: Review of facility policy, Person-Centered Care Plan dated last revised October 24, 2022, revealed, A baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient. Observation, on August 12, 2024, at 11:15 a.m. revealed that Resident R5 had a PICC line (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) in his right upper arm. Interview, at the time of the observation, Resident R5 stated that he received antibiotic therapy daily through his PICC line. Review of Resident R5's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated July 28, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including osteomyelitis (bone infection) of the left ankle and foot. Continued review revealed that the resident had a surgical wound and was receiving IV medications and antibiotics. Review of progress notes for Resident R5 revealed a nursing note, dated July 21, 2024, at 8:59 p.m. which indicated that the resident had a PICC line in his right upper arm that was inserted prior to being admitted . Review of Medication Administration Records (MARs) for Resident R5 revealed a physician's order, dated July 22, 2024, for ceftriaxone (antibiotic medication) two grams, administer intravenously every 24 hours for infection until August 25, 2024. Continued review revealed that the medication was initiated on July 22, 2024, as prescribed and that the medication continued to be administered at the time of the survey. Review of Resident R5's care plan revealed that a care plan that includes instructions for the care and maintenance of the resident's PICC line was not initiated until August 12, 2024. Observation on August 13, 2024, at 8:55 a.m., revealed that Resident R58 had a PICC line in her right upper arm. Interview, at the time of the observation, Resident R58 stated that her PICC line was used for chemotherapy (treatment for cancer). (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R58's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including cancer and [NAME] Lymphoma (type of cancer that affects the immune system and white blood cells). Continued review revealed that the resident had IV access and received chemotherapy. Review of progress notes revealed a practitioner note, dated July 25, 2024, at 8:57 a.m., which indicated that Resident R58 had a double lumen PICC line to her right upper extremity and for nursing staff to maintain the PICC line for use at chemotherapy. Review of Resident R58's care plan revealed that a care plan that includes instructions for the care and maintenance of the resident's PICC line was not initiated until August 12, 2024. Interview on August 15, 2024, at 12:33 p.m. Employee E3, Regional Nurse, confirmed that baseline care plans were not developed within 48 hours of admission for Residents R5 and R58 related to their PICC lines. Pa Code 211.10(d) Resident care policies Pa Code 211.12(d)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based on a review of clinical records, facility policies and documentation, and interviews with staff, it was determined that the facility failed to develop and implement comprehensive person-centered plans of care in a timely manner, for two of 21resident records reviewed (Residents R16 and R27). Findings include: Review of facilities policy, Person Centered Care Plan, revised October 24, 2022, revealed that a comprehensive, individualized care plan will be developed within seven days after completion of the comprehensive assessment (admission, annual or significant change) and review and revise the care plan after each assessment. Review of Resident R16's clinical record revealed that resident was admitted on [DATE]. Further review of Resident R16's Admission MDS (Minimum Data Set- assessment of resident's needs) dated July 31, 2024, section title Health Conditions, revealed that Resident R16 had shortness of breath or trouble breathing when lying flat. Observation Resident R16 conducted on August 12, 2024, at 11:30 a.m. revealed that Resident R16 was wearing a nasal cannula connected to an oxygen concentrator. Resident R16 indicated that she usually has the oxygen on to help her breathe. Review of R16's physician's orders revealed an August 11, 2024, order to continue supplemental oxygen to maintain saturation greater than 92%. Interview on August 14, 2024, at 1:40 p.m. with Employee E10, Registered Nurse, confirmed that the resident was to receive continuous oxygen, and that she had just check her saturation level which was over 92%. Interview with the Director of Nursing (DON) on August 14, 2024, at 1:45 p.m. confirmed that the resident had an order for oxygen and was receiving oxygen but had no care plan developed for oxygen therapy. Review of Resident R27's clincial record revealed that resident was admitted on [DATE]. Review of R27's physician order, dated August 2, 2024, revealed the following treatment orders; Sacrum: Cleanse with wound cleanser, apply Medi-honey, cover with Border gauze, every day shift for pressure wound; left elbow: cleanse with wound cleanser, apply adaptic, cover with gauze, and wrap with kling., every day shift for abrasion; left forearm: cleanse with wound cleanser, apply adaptic, Calcium alginate, cover with gauze and wrap with kling. , every day shift for skin tear; right forearm: cleanse with wound cleanser, apply adaptic and wrap with kling, every day shift for abrasion; right heel: cleanse with wound cleanser, apply Betadine, cover with gauze and wrap around with kling, every day shift for deep tissue injury (DTI). On August 14, 2024, at 9:47 a.m., observed that, a Licensed Nurse, E21, administered pressure wound treatment to the Sacrum of R27 as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed Resident R27's clinical records revealed that there was no care plan developed for wound treatments for Resident R27. On August 14, 2024, at 10:20 a.m., interviewed the Unit Manager, Registered Nurse, E22, and confirmed the finding. 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38947 Based on staff interviews, review of facility policy and the review of clinical records, it was determined that the facility failed to ensure that activities of daily living related to bathing was provided for one out of 26 residents reviewed (Resident R48). Findings include: Review of the facility policy, Activities of Daily Living, with a revision date of May 1, 2023, indicated that when patients are assessed upon admission, quarterly and with a significant change to identify their status of activities of daily living, their inability to perform activities of daily living, their risk of decline in any activity of daily living and the resident's ability to improve in the identified activity of daily living (e.g. bathing, showering, toileting, eating, walking, transferring). The policy also indicated that adl (activities of daily living) care will be recorded in the resident's medical record, is reflective of the care provided by nursing staff, will be documented as close to the time that the care was provided and documented on every shift by thee nursing assistant. Review of Resident R48's August 2024 physician orders indicated that the resident was admitted into the facility on [DATE] with diagnoses of chronic kidney disease (the gradual loss of kidney function); hypertension (high blood pressure); chronic pain syndrome; cerebral infarction (a stroke) and encephalopathy (a term used to describe damage or disease that affects that brain). During an interview with the resident's wife on August 15, 2024 at 10:30 a.m. the resident' wife reported that it took the facility 3 weeks to provide her husband a shower when he was admitted into the facility. Review of the residents shower record from July 25, 2024 through August 14, 2024 did not document that the resident was offered to take a shower or tub bath and if so, what his response was. Bed bath's were recorded on the following days for the year, 2024: 7/28 7/30 7/31; 8/4; 8/6 ;8/9; 8/13. During an interview with the Unit Manager (Employee E23)on August 15, 2024 at 3:34 p.m. Employee E23 reported that the resident is scheduled for showers on Wednesday and Saturdays. During the interview no additional evidence in the clinical record could be provided to show evidence that the resident had been offered showers on his assigned 2 shower days a week or any other days of the week. 28 Pa. Code 211,12(d)(1)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to obtain and follow physician orders related to diet, urinary catheters and wound care for two of 26 residents reviewed (Residents R168 and R265). Findings include: Observation on August 12, 2024, at 10:17 a.m. revealed that Resident R265 had a dressing on her right knee; the dressing was dated August 9, 2024, at 8 p.m. Review of Resident R265's Admission Assessment, dated August 7, 2024, at 3:00 p.m. revealed that the resident was admitted to the facility on [DATE], with a diagnosis of right knee septic arthritis (infection of the knee). Review of physician's orders for Resident R265, revealed an order, dated August 9, 2024, to cleanse right knee surgical incision with normal saline, pat dry, then apply clean dry dressing daily; monitor for any signs or symptoms of infection or drainage from suture site. Continued observation and interview on August 12, 2024, at 10:51 a.m. revealed that Employee E4, licensed nurse, confirmed that the dressing on Resident R265's right knee was dated August 9, 2024, at 8 p.m. and that the dressing was prescribed by the physician to be changed daily. Employee E4, licensed nurse, then proceeded to complete the dressing change for the resident. Review of the August 2024 physician orders for Resident R168 was admitted into the facility for respite care services with diagnosis that includes the following: cerebral vascular disease; malnutrition and dementia; and the need for mechanically altered diet/thickened liquids. Continued review of the resident' August 2024 physician ordered included a physician's order dated August 2024 for the resident to have a puree texture diet with thick liquids that are nectar consistency (a liquid consistency that is reserved for individuals who difficulty swallowing. The consistency is easily pourable and comparable to apricot nectar or thicker cream soups). During an observation in the resident's room on August 12, 2024 at 1:15 p.m. The resident was observed eating her lunch on her bedside table. Next to her lunch, a white styrophome cup was observed filled with water with a lid and a straw inserted. Employee E5 (licensed nurse) came to the room to remove the cup and confirmed that the resident should not have had the water served to her. 28 Pa Code 211.12(d)(1)(5) Nursing services

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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** 39344 Based on observations, review of facility policies, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to provide care and assessments consistent with professional standards of practice related to intravenous therapy for three of four residents reviewed for intravenous therapy (Residents R5, R58 and R265). Findings include: Review of facility policy, Assessment of the Patient Receiving IV Therapy [intravenous therapy - therapy that delivers liquid substances directly into a vein] dated September 2022, revealed, Assess vascular access device function by aspirating for a blood return and flushing prior to each intermittent use (intermittent medication administration) and as clinically indicated with continuous infusions. Assess the catheter insertion site and surrounding area for redness, tenderness, swelling, and drainage by visual inspection and palpation through the intact dressing. Recommended minimum assessment of midlines and central venous access devices is once every 24 hours. Measure the external length of the midline or central venous access device and compare to the length documented at insertion, during each dressing change and when catheter dislodgement is suspected. Measure upper arm circumference when clinically indicated to assess the presence of edema and possible deep vein thrombosis. Measure 10 cm above the insertion site. Review of facility policy, Dressing Change for Vascular Access Devices dated August 2012, revealed, Central venous access devices . dressings are changed every 7 [seven] days and PRN [as needed]. Observation, on August 12, 2024, at 11:15 a.m. revealed that Resident R5 had a PICC line (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) in his right upper arm; the dressing was dated August 5, 2024. Interview, at the time of the observation, Resident R5 stated that he received antibiotic therapy daily through his PICC line and that the line was recently changed due to dislodgement. Review of Resident R5's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated July 28, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including osteomyelitis (bone infection) of the left ankle and foot. Continued review revealed that the resident had a surgical wound and was receiving IV medications and antibiotics. Review of progress notes for Resident R5 revealed a nursing note, dated July 21, 2024, at 8:59 p.m. which indicated that the resident had a PICC line in his right upper arm that was inserted prior to being admitted . Review of Medication Administration Records (MARs) for Resident R5 revealed a physician's order, dated July 22, 2024, for ceftriaxone (antibiotic medication) two grams, administer intravenously every 24 hours for infection until August 25, 2024. Continued review revealed that the medication was initiated on July 22, 2024, as prescribed and that the medication continued to be administered at the time of the survey. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of progress notes for Resident R5 revealed a practitioner note, dated August 7, 2024, at 8:21 a.m. which indicated that the resident's PICC line was replaced on August 6, 2024, due to dislodgement. Further review of Resident R5's clinical record, including physician orders, progress notes and MARs revealed that there was no indication that the resident's PICC line dressing was changed at any time between July 21, 2024, through August 5, 2024, a period of over two weeks. There were no physician orders or MAR documentation to indicate if the PICC line was flushed or what type of flush solution should be used. There was no indication on the MARs or progress notes of any PICC line assessments measurements, such as arm circumference and external catheter length. Observation on August 13, 2024, at 8:55 a.m., revealed that Resident R58 had a PICC line in her right upper arm; the dressing was dated August 7, 2024. Interview, at the time of the observation, Resident R58 stated that her PICC line was used for chemotherapy (treatment for cancer) and that during her first week of admission to the facility, nursing staff did not flush her PICC line to maintain its's patency. Review of Resident R58's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], and had diagnoses including cancer and [NAME] Lymphoma (type of cancer that affects the immune system and white blood cells). Continued review revealed that the resident had IV access and received chemotherapy. Review of progress notes revealed a practitioner note, dated July 25, 2024, at 8:57 a.m., which indicated that Resident R58 had a double lumen PICC line to her right upper extremity and for nursing staff to maintain the PICC line for use at chemotherapy. Review of MAR's for Resident R58 revealed a physician's order, dated July 30, 2024, to flush the resident's PICC line with sodium chloride 0.9% solution, use ten milliters intravenously every twelve hours for patency. Continued review revealed that there no indication that the resident's PICC line was flushed between July 24 through July 29, 2024. Continued review of the MARs revealed that on July 30 and 31, 2024 at 8:00 p.m. that the flushes were not administered and to see nurses note. Review of eMAR (electronic MAR) notes, dated July 30, 2024, at 9:46 p.m. revealed that the flush was not administered due to Medication on order. Continued review revealed another eMAR note, dated July 31, 2024, at 9:26 p.m. which indicated that the flush was not administered due to On order. Continued review of MARs for Resident R58 revealed a physician's order, dated July 30, 2024, to change the resident's PICC dressing weekly. MARs indicated that the dressing was changed on July 30 and August 6, 2024. Review of eMAR notes, dated July 30, 2024, revealed that the PICC dressing was changed and that site remains unremarkable. Review of eMAR notes from August 7, 2024, at 8:54 a.m. revealed that PICC dressing was changed. There was no indication on the MARs or progress notes of any PICC line assessments measurements, such as arm circumference and external catheter length. Observation on August 12, 2024, at 10:17 a.m. revealed that Resident R265 had a PICC line in her right upper arm; the dressing was dated August 7, 2024. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R265's Admission Assessment, dated August 7, 2024, at 3:00 p.m. revealed that the resident was admitted to the facility on [DATE], with a diagnosis of right knee septic arthritis (infection of the knee), that she requires intravenous antibiotics and has a PICC line in her right upper arm. Review of progress notes for Resident R265 revealed a practitioner note, dated August 7, 2024, at 12:41 p. m. which indicated that the resident required intravenous cefazolin (antibiotic medication) every eight hours through September 12, 2024, related to right knee septic arthritis and for nursing to maintain PICC line. Review of Resident R265's MARs revealed physician's orders, dated August 7 and 13, 2024, for cefazolin (antibiotic medication) two grams, administer intravenously every eight hours for acute bacterial arthritis until September 12, 2024. Continued review revealed that the medication was initiated on August 7, 2024, as prescribed and that the medication continued to be administered at the time of the survey. Continued review of MARs and physician orders for Resident R265 revealed that there were no orders for PICC line flushes, PICC line dressing changes or PICC line assessments/measurements. Interview on August 15, 2024, at 12:33 p.m. Employee E3, Regional Nurse, confirmed that PICC line care was not provided in accordance with professional practice standards for Residents R5, R58 and R265. Pa Code 211.10(d) Resident care policies Pa Code 211.12(d)(1) Nursing services Pa Code 211.12(d)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on staff interviews and the review of clinical records, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of one dialysis residents reviewed (Resident R48). Findings include: Review of Resident R48's clinical record revealed that the resident was admitted to the facility on [DATE], and that Resident R48 had diagnoses of End-Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Review of Resident R48's physician order, dated July 26, 2024, revealed that Resident R48 received dialysis treatment at an outpatient dialysis facility on Mondays, Wednesdays, and Fridays on 7/29/24; 8/5/24; and 8/7/24. Review of Resident R48's Hemodialysis Communication Record revealed that on July 29, 2024, and on August 5, 2024, it was lacking all the information to be completed by licensed nurse for dialysis patient prior to dialysis treatment, and all the information to be completed by licensed nurse for dialysis patient's post dialysis treatment. Resident R48's Hemodialysis Communication Record also revealed that on August 7, 2024, it was lacking all the information to be completed by licensed nurse for dialysis patient's post dialysis treatment. Interview with the licensed nurse of second floor, Employee E21, on August 13, 2024, at 11:10 a.m., confirmed lack of communication with dialysis center. 28 Pa Code 211.12(d)(1)(5) Nursing services 28 Pa Code 211.12(d)(3) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39344 Based on observations, review of the Pennsylvania Nurse Practice Act, clinical record reviews, review of personnel files and interviews with residents and staff, it was determined that the facility failed to assure that nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs for five of five personnel files reviewed for competency evaluations (Employees E11, E12, E13, E14 and E15) and for four of four residents reviewed for intravenous therapy (Residents R5, R58, R265 and R266.) Findings include: Review of the Pennsylvania Nurse Practice Act for Registered Nurses (RNs), 49 Pa Code 21.12, revealed that, Performing venipuncture and administering and withdrawing intravenous fluids are functions regulated by this section, and these functions may not be performed unless: . (3) The registered nurse who administers parental fluids, drugs or blood has had instruction and supervised practice in administering parental fluids, blood or medications into the vein. Review of the Pennsylvania Nurse Practice Act for Licensed Practical Nurses (LPNs), 49 Pa Code 21.145, revealed that, An LPN may only perform the IV therapy functions for which the LPN possesses the knowledge, skill and ability to perform in a safe manner. Review of the Facility Assessment, dated reviewed July 1, 2024, revealed that, Staff training/education and competencies are necessary to provide support and care needed for the facility's short term resident population. Continued review revealed that required competencies include: activities of daily living, privacy, range of motion, transfers, mechanical lifts and infection control practices. Further review revealed that the facility provides resident care and services including: mobility and fall prevention, bowel and bladder programs, skin and wound care, mental health services, medication administration including administration of intravenous medications, pain management, management of medical conditions, nutrition services and psychosocial support. Review of Employee E11's personnel file revealed that the employee was hired by the facility on July 16, 2024, as a nurse aide. Review of Employee E12's personnel file revealed that the employee was hired by the facility on July 16, 2024, as a registered nurse. Review of Employee E13's personnel file revealed that the employee was hired by the facility on July 9, 2024, as a licensed practical nurse. Review of Employee E14's personnel file revealed that the employee was hired by the facility on July 2, 2024, as a nurse aide. Review of Employee E15's personnel file revealed that the employee was hired by the facility on May 21, 2024, as a registered nurse. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of personnel files for Employees E11, E12, E13, E14 and E15 revealed no evidence that the employees received any skills competency evaluations to ensure competency of hands-on skills and techniques necessary to care for residents' needs. Observation, on August 12, 2024, at 11:15 a.m. revealed that Resident R5 had a PICC line (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) in his right upper arm. Interview, at the time of the observation, Resident R5 stated that he received antibiotic therapy daily through his PICC line. Review of Medication Administration Records (MARs) for Resident R5 revealed a physician's order, dated July 22, 2024, for ceftriaxone (antibiotic medication) two grams, administer intravenously every 24 hours for infection until August 25, 2024. Continued review revealed that the medication was initiated on July 22, 2024, as prescribed and that the medication continued to be administered at the time of the survey. Observation on August 13, 2024, at 8:55 a.m., revealed that Resident R58 had a PICC line in her right upper arm. Interview, at the time of the observation, Resident R58 stated that her PICC line was used for chemotherapy (treatment for cancer). Review of MAR's for Resident R58 revealed a physician's order, dated July 30, 2024, to flush the resident's PICC line with sodium chloride 0.9% solution, use ten milliters intravenously every twelve hours for patency. Observation on August 12, 2024, at 10:17 a.m. revealed that Resident R265 had a PICC line in her right upper arm. Review of Resident R265's MARs revealed physician's orders, dated August 7 and 13, 2024, for cefazolin (antibiotic medication) two grams, administer intravenously every eight hours for acute bacterial arthritis until September 12, 2024. Continued review revealed that the medication was initiated on August 7, 2024, as prescribed and that the medication continued to be administered at the time of the survey. Observation on August 13, 2024, at 9:10 a.m. Resident R266 had a PICC line in her right upper arm. Interview, at the time of the observation, Resident R266 stated that her PICC line was being used for antibiotic therapy. Review of Resident R266's MARs revealed physician's orders, dated August 7, 2024, for piperacillin-sod-tazobactam (antibiotic medication), administer intravenously every eight hours for osteomyelitis (bone infection) for 14 days. Continued review revealed that the medication was initiated on August 8, 2024, and that the medication continued to be administered at the time of the survey. Interview on August 14, 2024, at 2:15 p.m. the Director of Nursing confirmed that she was unable to provide any evidence of skills competency evaluations for Employees E11, E12, E13, E14 and E15. Continued interview revealed that she was unable to provide any evidence of IV skills trainings and competency evaluations for Employees E12, E13 and E15. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on August 15, 2024, at 12:33 p.m. Employee E3, Regional Nurse, revealed that the facility had four residents who required intravenous therapy at the time of the survey. Employee E3, Regional Nurse, was unable to provide any documentation at the time of the survey of skills competency evaluations to ensure competency of hands-on skills and techniques necessary to care for residents' needs for Employees E11, E12, E13, E14 and E15. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(d) Staff development

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 39344 Based on a review of facility documentation and interviews with staff, it was determined that the facility failed to complete performance reviews for three of three nurse aides personnel files reviewed related to performance reviews as required (Employees E16, E17 and E18). Findings include: Review of facility documentation pertaining to current employees, revealed that Employee E16 was hired by the facility as a nurse aide on July 8, 2002; Employee E17 was hired as a nurse aide on April 19, 2022; and Employee E18 was hired as a nurse aide on December 30, 2019. On August 13, 2024, at 11:54 a.m. annual performance reviews for Employees E16, E17 and E18 were requested from the Nursing Home Administrator and Director of Nursing. Interview on August 14, 2024, 10:06 a.m. the Nursing Home Administrator revealed that the facility had not completed any performance reviews for any staff, including Employees E16, E17 and E18. 28 Pa. Code 201.19(2) Personnel policies and procedures

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based on a review of clinical records, review of facility policy and facility documentation, and staff interviews, it was determined the facility failed to implement a complete drug regimen review process for three of three residents reviewed (Resident R16, R5 and R270). Findings Include: Review of the facility policy, Medication Monitoring, Medication Regimen Review (MRR) and Reporting revealed that the Drug Regimen Review is a thorough evaluation of the medication regiment of a resident. And that the resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. Review of Resident R16's clinical record revealed that resident was admitted on [DATE], with diagnoses including glaucoma (condition where the eye's optic nerve, which provides information to the brain, is damaged with or without raised intraocular pressure. If untreated, this will cause gradual vision loss). A review of the July 31, 2024, pharmacy recommendation for Resident R16 revealed the following recommendation: Resident is currently receiving the following ophthalmic medications with their respective administration times: Latanoprost - 9:00 p.m. Rhopressa - 9:00 p.m. Brimonidine - 9:00 a.m., 5:00 p.m. Dorzolamide/Timolol - 1:00 p.m., 5:00 p.m. Artificial Tears - 9:00 a.m., 1:00 p.m., 5:00 p.m., 9:00 p.m. When ophthalmics are administered at the same time please be sure to separate administration of each ophthalmic agent by at least 5 minutes. Further review of Resident R16's physician orders did not reveal any changes in the timing of the ophthalmic agents prescribed or order to separate each agent by at least 5 minutes. Interview with the Director of Nursing (DON) on August 14, 2024, at 1:00 p.m. where these recommendations and current physician orders were reviewed, confirmed that the pharmacy recommendations were not implemented for Resident R16's opthalmic agents. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R5's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated July 28, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including heart attack and coronary artery disease (damage in the heart's major blood vessels). Clinical record review for Resident R5 revealed a medication regimen review, dated July 24, 2024. The pharmacist recommended that the facility should monitor the resident for signs and symptoms of bleeding/bruising and thromboembolism (blood clot) due to the resident's use of Aspirin and Clopidogrel (blood thinning medications). The physician reviewed the recommendations on July 25, 2024, and noted that they agreed with the recommendation. Review of July 2024 and August 2024's physician orders for Resident R5 revealed that there were no orders added to reflect the pharmacist's recommendations. Review of physician orders for Resident R270 revealed that the resident was admitted to the facility on [DATE], and had diagnoses including anxiety disorder (intense, excessive, persistent worry or fear) and stroke accident (damage to the brain from interruption of its blood supply). Continued review revealed that the resident was prescribed Aspirin daily for coronary artery disease and Lorazepam every six hours as needed for anxiety. Clinical record review for Resident R270 revealed a medication regime review, dated August 8, 2024. The pharmacist recommended that the facility should monitor the resident for signs and symptoms of bleeding/bruising and thromboembolism due to the resident's use of Aspirin. The pharmacist also recommended that the facility should monitor the resident's behavior and side effects, as well as add a stop date, due to the resident's use of Lorazepam. The physician reviewed the recommendations on August 8, 2024, and noted that they agreed with the recommendations. Further review of August 2024 physician orders for Resident R270 revealed that there were no orders added to reflect the pharmacist's recommendations. Interview on August 14, 2024, at 1:47 p.m. the Director of Nursing confirmed that the pharmacist's recommendations for Residents R5 and R270 were not implemented. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39343 Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for one of three residents observed during medication administration. (Resident R220) Findings include: Observations conducted of medication administration on August 12, 2024, 9:20 a.m., with Registered Nurse , Employee E9, revealed that Resident R220 ordered Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate), Give 1 tablet by mouth two times a day for Tachycardia; Rosuvastatin Calcium Oral Tablet 20 MG (Rosuvastatin Calcium), Give 1 tablet by mouth one time a day for HLD; Sertraline HCl Oral Tablet 100 MG (Sertraline HCl), Give 1 tablet by mouth one time a day for depression. Registered Nurse , Employee E9, did not administered the medications listed above to Resident R220. Employee E9 stated that the Metoprolol Tartrate Oral Tablet 25 MG, Rosuvastatin Calcium Oral Tablet 20 MG, and Sertraline HCl Oral Tablet 100 MG were not available at that time. (Metoprolol Tartrate is a beta blocker used to treat a variety of conditions, including high blood pressure, chest pain, and irregular heartbeats. Rosuvastatin is a class of medications called Statins, which works by slowing the production of cholesterol in the body to decrease the amount of cholesterol that may build up on the walls of the arteries and block blood flow to the heart, brain, and other parts of the body. Sertraline is an antidepressant used to treat major depressive disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, and social anxiety disorder). Review of nursing progress notes for R220, dated August 12, 2024, 11:24 a.m., related with the non-administration of Sertraline HCl Oral Tablet 100 MG indicated as follows: Sertraline HCl Oral Tablet 100 MG (Sertraline HCl), Give 1 tablet by mouth one time a day for depression, not available, pharmacy called and will be delivered at 1 p.m.- run. Review of nursing progress notes for R220, dated August 12, 2024, 11: 25 a.m., related with the non-administration of Rosuvastatin Calcium Oral Tablet 20 MG indicated as follows: ; Rosuvastatin Calcium Oral Tablet 20 MG (Rosuvastatin Calcium), Give 1 tablet by mouth one time a day for HLD, Meds not available, pharmacy called and will be delivered at 1 p.m.- run. Review of nursing progress notes for R220, dated August 12, 2024, 11: 29 a.m., related with the non-administration of Metoprolol Tartrate Oral Tablet 25 MG indicated as follows: Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate), Give 1 tablet by mouth two times a day for Tachycardia, not given, Meds not available, Nurse Practitioner notified, pharmacy called and will be delivered at 1 p.m.- run. Review of Medication Administration Record(MAR) of R 220, revealed that passing on of medications Sertraline HCl Oral Tablet 100 MG, Rosuvastatin Calcium Oral Tablet 20 MG, and Metoprolol Tartrate Oral Tablet 25 MG were scheduled for administration at 9:00 a.m. of the day. At the time of the observation, interviewed Employee E9, and confirmed the above findings. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility incurred a medication error rate of 11.54%. 28 Pa Code 211.12(d)(1)(2)(5) Nursing Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, review of facility policies, review of facility documentation, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to maintain an effective infection control program related to infection surveillance for three of five residents reviewed with infections (Residents R5, R16 and R56), infection data reporting and infection committee meetings as required. Findings include: Review of facility policy, Infection Control Outcome and Process Surveillance and Reporting, dated revised March 1, 2024, revealed, The Infection Preventionist will conduct regular outcome surveillance which consists of collecting/documenting data on individual cases and comparing collective data to standard, written definitions of infection. Observation, on August 12, 2024, at 11:15 a.m. revealed that Resident R5 had a PICC line (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) in his right upper arm. Interview, at the time of the observation, Resident R5 stated that he received antibiotic therapy daily through his PICC line. Review of Resident R5's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated July 28, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including osteomyelitis (bone infection) of the left ankle and foot. Continued review revealed that the resident had a surgical wound and was receiving IV medications and antibiotics. Review of Medication Administration Records (MARs) for Resident R5 revealed a physician's order, dated July 22, 2024, for ceftriaxone (antibiotic medication) two grams, administer intravenously every 24 hours for infection until August 25, 2024. Continued review revealed that the medication was initiated on July 22, 2024, as prescribed and that the medication continued to be administered at the time of the survey. Review of Resident R16's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], with diagnoses including legal blindness. Continued review reveled that the resident was receiving antibiotic medications. Review of July 2024 Medication Administration Records (MARs) for Resident R16 revealed a physician's order, dated July 24, 2024, for vancomycin (antibiotic medication) eye drops, instill one drop in right eye every two hours for vision loss until July 26, 2024. Continued review revealed a physician's order, dated July 24, 2024, for tobramycin (antibiotic medication) eye drops, instill one drop in right eye every two hours for vision loss until July 26, 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of August 2024 Medication Administration Records (MARs) for Resident R16 revealed a physician's order, dated August 12, 2024, for azithromycin (antibiotic medication), give one tablet by mouth one time only for bronchitis (infection in the lungs) until August 12, 2024. Continued review revealed another physician's order, dated August 13, 2024, for azithromycin, give one tablet by mouth one time a day for bronchitis for two days. Review of Resident R56's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], with diagnoses including urinary tract infection. Continued review reveled that the resident was receiving antibiotic medications. Review of MARs for Resident R56 revealed a physician's order, dated July 14, 2024, for Amoxicillin, give two capsules by mouth every eight hours for urinary tract infection for three days. Continued review revealed a physician's order, dated July 13, 2024, for methenamine Hippurate, give one tablet by mouth at bedtime for urinary antibiotic. The medication initiated on July 13, 2024, as prescribed and continued to be administered at the time of the survey. Review of facility documentation pertaining to infection surveillance tracking logs for June, July and August 2024, revealed that Residents R5, R16 and R56 were not listed on the logs. Interview on August 14, 2024, at 12:55 p.m. the Director of Nursing confirmed that infection surveillance and tracking had not been completed for Residents R5, R16 and R56. Act 52 of 2007 mandates that nursing homes develop and implement comprehensive infection control plans and reporting of healthcare-associated infections as serious events. The Pennsylvania Patient Safety Reporting System (PA-PSRS) was created as a system for facilities to submit the required information. During an interview on August 12, 2024, at 2:23 p.m. information pertaining to PA-PSRS utilization data and healthcare-associated infections reporting as well as infection committee meeting minutes and attendance was requested from the Nursing Home Administrator, Director of Nursing and Employee E3, Regional Nurse. During a follow-up interview on August 13, 2024, at 12:21 p.m., the Director of Nursing and Employee E3, Regional Nurse, revealed that no one at the facility had access to the PA-PSRS system and that they were unable to provide any utilization or infection reporting data. During a follow-up interview on August 15, 2024, at 12:55 p.m. the Nursing Home Administrator confirmed that she was unable to provide any current documentation at the time of the survey of infection committee meetings. Continued interview revealed that the last documented infection committee meeting was conducted in November 2023. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(d) Management

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, review of facility policies, review of facility documentation, clinical record reviews and interviews with residents and staff, it was determined that the facility failed to maintain an effective antibiotic stewardship program for five of five of residents reviewed for antibiotics (Residents R5, R16, R56, R266 and R265). Findings include: Review of facility policy, Antibiotic Stewardship dated July 1, 2024, revealed, Centers will implement an Antibiotic Stewardship Program that include antibiotic use protocols and systems for monitoring antibiotic use. Observation, on August 12, 2024, at 11:15 a.m. revealed that Resident R5 had a PICC line (peripherally inserted central catheter - a thin soft tube inserted in a vein in the arm with the tip of the tube positioned in a large vein that carries blood to the heart) in his right upper arm. Interview, at the time of the observation, Resident R5 stated that he received antibiotic therapy daily through his PICC line. Review of Resident R5's Admission MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated July 28, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including osteomyelitis (bone infection) of the left ankle and foot. Continued review revealed that the resident had a surgical wound and was receiving IV medications and antibiotics. Review of Medication Administration Records (MARs) for Resident R5 revealed a physician's order, dated July 22, 2024, for ceftriaxone (antibiotic medication) two grams, administer intravenously every 24 hours for infection until August 25, 2024. Continued review revealed that the medication was initiated on July 22, 2024, as prescribed and that the medication continued to be administered at the time of the survey. Review of Resident R16's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], with diagnoses including legal blindness. Continued review reveled that the resident was receiving antibiotic medications. Review of July 2024 Medication Administration Records (MARs) for Resident R16 revealed a physician's order, dated July 24, 2024, for vancomycin (antibiotic medication) eye drops, instill one drop in right eye every two hours for vision loss until July 26, 2024. Continued review revealed a physician's order, dated July 24, 2024, for tobramycin (antibiotic medication) eye drops, instill one drop in right eye every two hours for vision loss until July 26, 2024. Review of progress notes for Resident R16 revealed a practitioner note, dated July 25, 2024, at 11:20 a.m. which indicated that the resident was admitted with orders for antibiotic eye drops to prevent infection until the resident has a surgical procedure to her eye. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of August 2024 Medication Administration Records (MARs) for Resident R16 revealed a physician's order, dated August 12, 2024, for azithromycin (antibiotic medication), give one tablet by mouth one time only for bronchitis (infection in the lungs) until August 12, 2024. Continued review revealed another physician's order, dated August 13, 2024, for azithromycin, give one tablet by mouth one time a day for bronchitis for two days. Review of progress notes for Resident R16 revealed a practitioner note, dated August 12, 2024, at 8:52 a.m. which indicated that the resident was evaluated for shortness of breath. The practitioner noted that a chest xray was completed on August 11, 2024 and revealed no acute cardiopulmonary disease. The practitioner prescribed azithromycin for three days for suspected bronchitis. Review of Resident R56's Admission MDS, dated [DATE], revealed that the resident was admitted to the facility on [DATE], with diagnoses including urinary tract infection. Continued review reveled that the resident was receiving antibiotic medications. Review of MARs for Resident R56 revealed a physician's order, dated July 14, 2024, for amoxicillin, give two capsules by mouth every eight hours for urinary tract infection for three days. Continued review revealed a physician's order, dated July 13, 2024, for methenamine Hippurate, give one tablet by mouth at bedtime for urinary antibiotic. The medication was initiated on July 13, 2024, as prescribed and continued to be administered at the time of the survey. Review of Resident R265's Admission Assessment, dated August 7, 2024, at 3:00 p.m. revealed that the resident was admitted to the facility on [DATE], with a diagnosis of right knee septic arthritis (infection of the knee), that she requires intravenous antibiotics and has a PICC line in her right upper arm. Review of progress notes for Resident R265 revealed a practitioner note, dated August 7, 2024, at 12:41 p. m. which indicated that the resident required intravenous cefazolin (antibiotic medication) every eight hours through September 12, 2024, related to right knee septic arthritis. Review of Resident R265's MARs revealed physician's orders, dated August 7 and 13, 2024, for cefazolin (antibiotic medication) two grams, administer intravenously every eight hours for acute bacterial arthritis until September 12, 2024. Continued review revealed that the medication was initiated on August 7, 2024, as prescribed and that the medication continued to be administered at the time of the survey. Review of progress notes for Resident R266 revealed a practitioner's note, dated August 8, 2024, at 6:48 p. m. which indicated that the resident was admitted to the facility that day and required long term intravenous (IV) antibiotics for osteomyelitis to her chronic non-healing sacral wound. Review of Resident R266's MARs revealed a physician's order, dated August 7, 2024, for piperacillin-sod-tazobactam (antibiotic medication) 3-0.375 grams, administer intravenously every eight hours for IV therapy for 14 days. Continued review revealed that the medication was initiated on August 8, 2024, and that the medication continued to be administered at the time of the survey. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility documentation pertaining to infection surveillance tracking logs for June, July and August 2024, revealed that Resident R265 had an unknown infection with an onset date of August 7, 2024. There were no listed antibiotics, infection site, organism, signs/symptoms or isolation precautions listed on the log. Continue review revealed that Resident R266 had an unknown infection with an onset date of August 7, 2024, located in a wound. There were no listed antibiotics, organism, signs/symptoms or isolation precautions listed on the log. Further review revealed that Residents R5, R16 and R56 were not listed on the infection surveillance tracking logs. Interview on August 13, 2024, at 12:21 p.m. the Director of Nursing revealed that the facility's process for Antibiotic Stewardship includes evaluating all infections to ensure that they meet minimum criteria for antibiotic use. Continued interview revealed that the facility uses an assessment tool that includes infection details, isolation requirements and treatments. Facility assessments for Residents R5, R16, R56, R266 and R265 were requested. Review of Resident R265's infection assessment revealed that the resident had an infection in her right knee. There was no indication of the infection type, organism, or antibiotic treatment. Review of Resident R266's infection assessment revealed that the resident had a bacterial infection in her wound. There was no indication of the organism or antibiotic treatment. Infection assessments for Residents R5, R16 and R56 were not available for review at the time of the survey. Interview on August 14, 2024, at 12:55 p.m. the Director of Nursing confirmed that infection and antibiotic assessments had not been completed for Residents R5, R16 and R56. Continued interview revealed that the antibiotics assessments for Residents R265 and R266 had not been completed properly and that no antibiotic review or stewardship practices had been completed for Residents R5, R16 and R56. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(d) Management

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **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 offer pneumococcal vaccines for two of five residents reviewed for vaccinations (Residents R46 and R37). Findings include: Facility polices for influenza and pneumococcal vaccines were requested from facility administrative staff on August 12, 2024, at 10:00 a.m. The policies were requested again on August 12, 2024, at 2:23 p.m.; August 13, 2024, at 12:21 p.m. and August 14, 2024, at 2:43 p.m. The policies were not provided for review at any the time during the survey. Clinical record review for Resident R46 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R46's clinical record that the resident was offered the pneumococcal vaccine. Review of hospital records, dated August 15, 2024, revealed that the resident was due for a pneumococcal vaccine but has never received one. Clinical record review for Resident R37 revealed that the resident was admitted to the facility on [DATE]. Continued review revealed that there was no indication in Resident R37's clinical record that the resident was offered the pneumococcal vaccine. Review of hospital records, dated August 15, 2024, revealed that the resident was due for a pneumococcal vaccine but has never received one. Documentation of pneumococcal vaccines for Residents R46 and R37 were requested from the Director of Nursing on August 13, 2024, at 1:16 p.m. During a follow-up interview at 1:57 p.m. the Director of Nursing confirmed that the information was not available for review. Interview on August 15, 2024, at 12:33 p.m. Employee E3, Regional Nurse, stated that vaccination status for Residents R46 and R37 were in their hospital records. Review of hospital records provided by the facility revealed no indication that either of the residents ever received the pneumococcal vaccine. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.18(d) Management

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 38947 Based on observations and staff interviews, it was determined that the facility failed to ensure that resident bathrooms were equipped with the appropriate call bell system for 3 out of 25 residents reviewed (Rooms 100,102 and 104) Findings include: During interview with the maintenance assistance, Employee E24 and the Nursing Home Administrator (NHA) on August 14, 2023 at 3:54 p.m. it was reported that the call bell system has been broken for the following rooms: 116, 100 102, 104, and 104. Rooms 100, 102 and 104 were confirmed to be currently occupied by residents. Continued interview with the maintenance assistance and the NHA revealed that all three residents were provided with a handheld call bell system with a lanyard attached so that they can wear it around their neck. During an observation in rooms 100 (Resident 315), 102 (Resident 26) and 104 (Resident R51) on August 14, 2024, at 11:00 a.m. the above referenced rooms were toured and the call bell system in the bathroom of each room also did not work to ensure that when the residents are utilizing that bathroom, they have a means to contact nursing staff for assistance should they not have their handheld call bell system with them or around their neck. During a discussion with the Nursing Home Administrator and the Regional Nurse on August 15, 2024, at 5:30 p.m. the need for a separate call bell system in the bathroom for residents was discussed. 28 Pa. Code 205.67(j) Electric requirements for existing construction

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 39344 Based on review of personnel files, facility documentation and interviews with staff, it was determined that the facility failed to ensure that an effective training program was maintained as required for five of ten staff reviewed related to training (Employees E20, E18, E11, E14 and E15). Findings include: Review of the Facility Assessment, dated reviewed July 1, 2024, revealed that, Staff training/education and competencies are necessary to provide support and care needed for the facility's short term resident population. Continued review revealed that required training topics include: effective communications; resident's rights; abuse, neglect and exploitation; infection control; and identification of resident changes in condition. Review of facility documentation pertaining to current employees, revealed that Employee E20 was hired by the facility as a licensed practical nurse on May 28, 2019, Employee E18 was hired as a nurse aide on December 30, 2019, Employee E11 was hired as a nurse aide on July 16, 2024, Employee E14 was hired as a nurse aide on July 2, 2024, and Employee E15 was hired as a registered nurse on May 21, 2024. Personnel records pertaining the trainings completed by Employees E20, E18, E11, E14 and E15 were requested from the Nursing Home Administrator and Director of Nursing on August 13, 2024, at 11:54 a.m. Review of Employee E20's personnel file revealed that no annual trainings had been completed by the employee between August 14, 2023, through August 13, 2024. Review of Employee E18's personnel file revealed that the employee had completed eight trainings between August 14, 2023, through August 13, 2024, that included: gait belt, hand hygiene, personal protective equipment, sliding board transfers, weighing patients, measuring patient height, protecting residents from assault and abuse, protecting resident's rights and dementia training. There was no documentation available for review at the time of the survey to indicate that the employee completed 12 hours of annual trainings or that training was completed on topics such as accident prevention, restorative nursing techniques, emergency preparedness, fire prevention, communication, QAPI (Quality Assurance Performance Improvement), ethics and behavioral health, as required. Review of Employee E11's personnel file revealed that no documentation was available for review at the time of the survey related to abuse training, as required. Review of Employee E14's personnel file revealed that no documentation was available for review at the time of the survey related to training for dementia, restorative nursing techniques, emergency preparedness, QAPI, ethics and behavioral health, as required. Review of Employee E15's personnel file revealed that no documentation was available for review at the time of the survey related to abuse training, as required. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on August 14, 2024, at 2:15 p.m. the Director of Nursing confirmed that the above items were not provided in the personnel files for Empoyees E20, E18, E11, E14 and E15. 28 Pa Code 201.19(7) Personnel policies and procedures 28 Pa Code 201.20(a)(1-6) Staff development 28 Pa Code 201.20(b) Staff development 28 Pa Code 201.20(d) Staff development