STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396026	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Villa St Joseph	1030 State Street Baden, PA 15005

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on review of observations and staff interview, it was determined that the facility failed to provide a dignified dining experience for one of three unit dining rooms observed. (Carondelet Resident R14), and failed to protect and value residents' private space ([NAME] Resident R110, R215, and Fontbonne Resident R8) Findings include: Review of the facility policy Resident Rights dated 1/2/25, indicated that residents have the right to be treated with respect and dignity. During an observation of the Carondelet dining room on 2/24/25, at 11:54 p.m. it was revealed that Resident R14 was being assisted with lunch. Employee E19 was standing beside Resident R14 while feeding her. During an interview on 2/24/25, at 12:25 p.m. Employee E19 confirmed the facility failed to provide a dignified dining experience for Resident R14. During an observation on [NAME] Unit on 2/24/25, at 12:09 p.m. Nurse Aide (NA) Employee E20 was seen entering Resident 110's room without knocking or requesting permission to enter. During an observation on [NAME] Unit on 2/24/25, at 12:11 p.m. NA Employee E20 was seen entering Resident 215's room without knocking or requesting permission to enter. During an interview on 2/24/25, at 12:11 p.m. NA Employee E20 confirmed that she failed to knock prior to entering Resident R110, and R215's rooms which failed to protect and value the residents' private space. During an observation on Fontbonne Unit on 2/26/25, at 1:28 p.m. Licensed Practical Nurse (LPN) Employee E2 was performing a wound dressing change and failed to close the door for privacy for Resident R8. During an interview on 2/26/25, at 2:05 p.m. LPN Employee E2 confirmed that she failed to close the door to provide privacy during a wound dressing change for Resident R8. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.29(a)Resident Rights.

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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** 50075 Based on review of clinical record, and staff interview, it was determined that the facility failed to develop a baseline care plan that included Life Vest (a wearable defibrillator designed to protect residents from sudden cardiac death) interventions needed to provide effective and person-centered care for two of ten residents (Resident R49 and R314). Findings include: Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident R49's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/16/25, indicated diagnoses of high blood pressure, septicemia (an infection of the blood), heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R49's baseline care plan dated 2/9/25, failed to include that the resident had a Life Vest. Review of the clinical record indicated Resident R314 was admitted to the facility on [DATE]. Review of Resident R314's MDS dated [DATE], indicated diagnoses of heart failure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and high blood pressure. Review of Resident R314's baseline care plan completed on 2/13/25, indicated the resident had a Life Vest, Heart Failure. The baseline care plan failed to provide person-centered initial goals necessary to properly care for resident upon admission and failed to address resident specific health and safety concerns to prevent decline or injury with a Life Vest. During an interview on 2/28/25, at 10:06 a.m. the Corporate Clinical Coordinator Employee E7 confirmed that the facility failed to develop a baseline care plan that included Life Vest interventions needed to provide effective and person-centered care for two of ten residents (Resident R49, and R314). 28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50075 Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop care plans that included instructions to provide person centered care for three of ten residents (Resident R49, R228, and R314). Findings include: Review of facility's policy Care Plan Revisions Upon Status Change dated 1/2/25, indicated the facility is to provide a process for reviewing and revising the care plan. Care plans may be modified as needed by a staff member. The care plan will be updated with the new or modified interventions. Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident R49's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/16/25, indicated diagnoses of high blood pressure, septicemia (an infection of the blood), heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R49's care plan dated 2/9/25, failed to reveal a care plan with goals and interventions for a Life Vest. During an interview on 2/24/25, at 3:42 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that a comprehensive resident care plan was complete for resident care needs for Resident R49. Review of the clinical record revealed that Resident R228 was admitted to the facility on [DATE]. Review of Resident R228's MDS dated [DATE], indicated diagnoses of fractured knee joint, fractured shin, and history of falling. Review of resident R228's clinical record revealed a physician's order dated 2/16/25, for gluten (a protein found in wheat, rye, and barley) free, and lactose (a natural sugar found in cows' milk) restricted diet. Review of Resident R228's care plan dated 2/16/25, failed to reveal a person-centered care plan that contained the above diet order. During an interview on 2/27/25, at 9:38 a.m. Registered Dietitian Employee E24 confirmed that the facility failed to develop a person-centered care plan for Resident R228's diet order. Review of the clinical record indicated Resident R314 was admitted to the facility on [DATE]. Review of Resident R314's MDS dated [DATE], indicated diagnoses of heart failure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and high blood pressure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During Resident R314's interview on 2/24/25, at 11:15 a.m. a charging station for Life Vest batteries was observed on the window ledge and resident confirmed that she was wearing a Life Vest. Review of Resident R314's care plan, dated on 2/12/25, failed to reveal a care plan with goals and interventions for a Life Vest. During an interview on 2/24/25, at 3:42 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that a comprehensive resident care plan was complete for resident care needs for Resident R314. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on clinical records and staff interview, it was determined that the facility failed to revise a care plan for two of seven residents (Resident R70 and R90) to accurately reflect the current status of the resident. Findings include: Review of clinical record indicated Resident R70 was admitted [DATE], with diagnoses which included sepsis (condition that occurs when the body's immune system overreacts to an infection), bacterial pneumonia and dysphagia (swallowing difficulties). A review of Resident R70's Minimum Data Set (MDS-a periodic assessment of resident care needs) dated 2/3/25, indicated diagnoses remained current. Review of Resident R70's physician orders dated 1/23/25 indicated 1500cc fluid restriction, allergic to fish/shellfish. Review of Resident R70's Resident Care Plan dated 2/3/25, was not updated to include fluid restriction or allergy. During an interview on 2/26/25, at 11:15 a.m. Registered Dietetic Technician Employee E14 confirmed the facility failed to revise care plan for Resident R70 as required. Review of the clinical record revealed that Resident R90 was admitted to the facility on [DATE]. Review of Resident R90s MDS dated [DATE], indicated diagnoses of difficulty swallowing, malnutrition (lack of nutrients to the body), and aphonia (complete or partial loss of voice). Section K0520B indicated that a feeding tube was present. Review of Resident R90's clinical record revealed a physician's order for Glucerna 1.2 (a nutritional formula that is administered through a feeding tube and designed to help control blood glucose levels) at 50 milliliters (ml) per hour from 4:00 p.m. through 10:00 a.m. with 100 ml water flush every 4 hours. Review of Resident R90's care plan dated 12/20/24, failed to reveal a person-centered care plan that included her current tube feed and flush orders. During an interview on 2/27/25, at 9:35 a.m. Registered Dietitian Employee E24 confirmed that the facility failed to revise the care plan and failed to include resident specific details. 28 Pa. Code 211.12(d)(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** 41984 Based on observation, clinical record review and staff interview it was determined that the facility failed to clarify a physician's order for four of seven sampled residents (Resident R49, R57, R70, and R314). Findings include: Review of clinical record revealed a Printable Discharge Form dated 2/6/25, that included correspondence between the facility and the discharging hospital, that stated that Resident R49 will be getting a Life Vest (a wearable defibrillator designed to protect from sudden cardiac death) on discharge. Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident R49s MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/16/25, indicated diagnoses of high blood pressure, septicemia (an infection of the blood), heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R49's clinical record revealed a Nursing Progress note dated 2/10/25, that stated Life Vest intact. During an observation and interview on 2/24/25, at 2:03 p.m. in Resident R49's room, a charging station for Life Vest batteries was noted to be on the window ledge, which Resident R49 confirmed, and that he was indeed wearing a Life Vest which he had upon admission to the facility. Review of Resident R49's clinical record conducted on 2/24/25, at 12:59 p.m. did not include orders for a Life Vest. During an interview on 2/24/25, at 3:42 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to obtain orders for care of a Life Vest for Resident R49. Review of clinical record indicated Resident R70 was admitted [DATE], with diagnoses which included sepsis (condition that occurs when the body's immune system overreacts to an infection), bacterial pneumonia and dysphagia (swallowing difficulties). A review of Resident R70's MDS dated [DATE], indicated diagnoses remained current. Review of Resident R70's physician orders dated 1/23/25 indicated 1500cc fluid restriction. Physician order did not indicate what fluid nursing or dietary provided. Review of Resident R57's admission record indicated he was originally admitted on [DATE], with diagnoses that included protein calorie malnutrition, diabetes mellitus (chronic metabolic disease characterized by high blood sugar (glucose) levels) and dysphagia (difficulty swallowing). A review of Resident R57's MDS dated [DATE], indicated that the diagnoses remained current. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R57's physician orders dated 2/10/25 indicated enteral feed, Nepro, 45 ml/hr. Physician order did not indicate the administration route and what the tube is providing. During an interview on 2/26/25, at 11:00 a.m. the Dietetic Technician Employee E14 confirmed that the failed to clarify physician orders as required. Review of Resident R314's clinical record revealed a Printable Discharge Form dated 2/12/25, that included correspondence between the facility and the discharging hospital, in which the hospital had documented, I was just told the patient has a life vest, she has it here. Will that be, okay? On 2/12/25, at 10:53 a.m. the facility responded, that is fine. Resident was accepted to facility and admitted later that day. Review of the clinical record indicated Resident R314 was admitted to the facility on [DATE]. Review of Resident R314's MDS dated [DATE], indicated diagnoses of heart failure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and high blood pressure. During Resident R314's interview on 2/24/25, at 11:15 a.m. a charging station for Life Vest batteries was observed on the window ledge and resident confirmed that she was wearing a Life Vest. Review of Resident R314's current orders on 2/24/25, at 12:55 p.m. failed to reveal a physician order for a Life Vest. During an interview on 2/24/25, at 3:42 p.m. the NHA confirmed that the facility failed to obtain orders for care of a Life Vest for Resident R314. 28 Pa Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(6) Staff development. 28 Pa Code 201.29(a) Resident rights. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, clinical records, observation, and interviews with staff, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for two of four residents (Resident R35, and Closed Resident Record CR265). Findings include: Review of the facility policy Wound Treatment Management last reviewed 1/2/25, indicated that wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Review of facility policy Pressure Injury Prevention Guidelines dated 1/2/25, indicated interventions will be documented in the care plan and communicated to all relevant staff. Review of the clinical record revealed that Resident R35 was admitted to the facility on [DATE]. Review of Resident 35's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/11/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Section M0300 indicated that stage 3 pressure areas (pressure injury that have burrowed past the second layer of the skin and reached fat layers beneath) are present. Review of Pressure Ulcer list provided by the facility, dated 2/25/25, indicated that Resident R35 had stage three pressure ulcer on left and right ischium (the curved bone forming the base of each half of the pelvis). Review of Resident R35's clinical record revealed a physician's order dated 2/12/25, to cleanse right and left ischium wounds with normal saline solution (a solution of water and salt), apply Medihoney (a wound gel) and calcium alginate (a highly absorptive dressing that creates a protective gel and maintains a moist wound environment) cover with Island dressing (a bandage with and absorbent center and an adhesive border) daily and as needed for soilage/dislodgment. Review of Resident R35's Treatment Administration Record (TAR) indicated that she did not receive the above treatment as ordered on 2/12/25, 2/13/25, 2/19/25, and 2/24/25. During an interview on 2/27/25, at 1:57 p.m. the Director of Nursing confirmed the facility failed to make certain that Resident R35 was provided necessary treatment and services for her pressure ulcer/injury. Review of the clinical record indicated Closed Resident Record CR265 was admitted to the facility on [DATE]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Closed Resident Record CR265's MDS dated [DATE], indicated diagnoses of high blood pressure, Peripheral Vascular Disease (PVD - circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and fusion of spine, lumbar region. Review of a Wound Evaluation & Management Summary dated 1/7/25, indicated Closed Resident Record CR265 had the following wounds: - Stage 4 Pressure Wound (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to the sacrum; duration > 69 days - Unstageable DTI (Deep Tissue Injury - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) of the right posterior and medial heel; duration > 48 days - Stage 3 Pressure Wound of the left lateral foot; duration > 34 days - Stage 4 Pressure Wound of the right lateral foot; duration > 27 days - Unstageable DTI of the right medial foot; duration > 6 days - Unstageable DTI of the right medial ankle; duration > 6 days - Unstageable DTI of the right medial shin; duration > 6 days Review of Closed Resident Record CR265's care plan failed to reveal goals and interventions related to the care of his pressure wounds and deep tissue injuries. During an interview on 2/28/25, at 11:29 a.m. Corporate Clinical Coordinator Employee E7 confirmed that the facility failed to develop a plan of a care including goals and interventions related to the care of Closed Resident Record CR265's pressure wounds and deep tissue injuries. 28 Pa. Code: 201.29(a) Resident Rights. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of two residents (Residents R90). Findings include: Review of facility policy Enteral Feeding dated 1/2/25, indicated enteral feedings may be prescribed who are physically or psychologically unable to take food by mouth in amounts that will support adequate nutrition. Review of Resident R90's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R90's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/11/25, indicated diagnoses of high blood pressure, cancer (uncontrolled growth and spread of abnormal cells), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). MDS section K-Swallowing/Nutritional Status K0520 indicated a feeding tube. Review of current physician orders indicated Resident R90 is NPO (nothing by mouth). Review of current physician orders indicated the following: - Amoxicillin-Pot Clavulante tablet (antibiotic used to treat infections). Give one tab by mouth in the morning for tumor drainage. - Levsin Oral Tab (used to dry up secretions). Give 0.125 mg (milligram) by mouth every four hours as needed for secretions. - Synthroid (used to treat Thyroid disorders). Give 100 mcg (micrograms) by mouth in the afternoon. During an interview on 2/27/25, at 1:19 p.m. the Director of Nursing confirmed that the resident was ordered medication to be taken by mouth and the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications for one of two residents (Resident R90). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) 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** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to obtain a complete order for a resident with a tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube), failed to obtain a physician order for use of a CPAP machine (a form of non-invasive ventilation (NIV) therapy used to facilitate breathing), and failed to develop a plan of care for two of five residents (Resident R90 and Closed Resident Record CR264). Findings include: Review of facility policy Noninvasive Ventilation (CPAP, BiPAP, Trilogy) dated 1/2/25, indicated the facility will obtain an order for the use of a CPAP, BiPAP or Trilogy device and settings from the practitioner. Review of Resident R90's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R90's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/11/25, indicated diagnoses of high blood pressure, cancer (uncontrolled growth and spread of abnormal cells), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section O: Special Treatments, Procedures, and Programs O100E1 Tracheostomy care is marked while a resident. Review of Resident R90's physician's orders, indicated tracheostomy care with inner cannula every shift. Keep resident upright at least 30 degrees during care. Take inner cannula out for cleansing. Apply new drain sponge around trach site. Review of Resident R90's care plan dated 12/23/24, indicated resident has a tracheostomy. Tube Out Procedure: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat (a medical device). If tube cannot be reinserted, obtain medical help. During an interview on 2/27/25, at 1:10 p.m. Director of Nursing (DON) confirmed that Resident R90's physician orders and care plan failed to identify the correct kind and size of tracheostomy tube used for resident and failed to provide appropriate respiratory care for Resident R90. Review of the clinical record indicated Closed Resident Record CR264 was admitted to the facility on [DATE]. Review of Closed Resident Record CR264's MDS dated [DATE], indicated diagnoses of high blood pressure, respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and obstructive sleep apnea (disorder that causes breathing to repeatedly stop and start during sleep). Review of a Health Status Note dated 5/8/24, at 12:3 a.m. stated, Upon putting on CPAP head strap was missing. When asked about it she [Closed Resident Record CR264] stated I probably ate it, strap was located behind night stand. CPAP applied and in place and functioning. (continued on next page)

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	396026	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Villa St Joseph	1030 State Street Baden, PA 15005

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Closed Resident Record CR264's clinical record failed to reveal a physician order for CPAP settings or usage. Review of Closed Resident Record CR264's care plan failed to reveal the development of goals and interventions related to the resident's CPAP usage. During an interview on 2/28/25, at 10:12 a.m. Corporate Clinical Coordinator Employee E7 confirmed that the facility failed to obtain a physician order for use of a CPAP machine and failed to develop a plan of care related to CPAP usage for Closed Resident Record CR264. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(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. 41984 Based on review of resident clinical records and staff interview, it was determined the facility failed to provide consistent and complete communication with the dialysis (treatment that helps body remove extra fluid and waste products) center for one of one resident receiving hemodialysis (Resident R165) for two of four days. Findings include: A review of Resident R165's MDS (MDS-a periodic assessment of resident care needs) dated 2/14/25, with the diagnosis of end stage renal disease (permanent condition in which the kidneys can no longer filter the blood), diabetes mellitus and abnormalities of gait and mobility. A review of Resident R165 physician orders last revised on 2/10/25, indicate dialysis Mondays, Wednesdays and Fridays. A review of Resident R165's dialysis binder indicated dialysis sheets completed on 2/10/25 and 2/17/25, incomplete 2/19/25 and 2/24/25. During an interview on 2/26/25, Registered Nurse Employee E15 confirmed the dialysis communication forms were incomplete for two of four days. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.5(f) Clinical records. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on manufacturer's instructions, clinical record reviews, and staff interviews it was determined that the facility failed to ensure that nursing staff had the specific competencies and skill sets necessary to provide care for a resident with a Life Vest (a wearable defibrillator designed to protect residents from sudden cardiac death), and placed two of two residents in immediate jeopardy in which health and safety were impacted (Resident R314, and R49). Findings include: Review of the [NAME] Life Vest Patient Manual updated 2021, indicated the following: Wear all day and all night Life Vest slides on and off like a backpack. If the garment fits loosely, call [NAME] (manufacturer). The garment should be snug against the skin. Remove Life Vest to bathe, shower, or change the garment, Turn on Life Vest by inserting the battery. Always have the garment on before inserting the battery. Every 24 hours, change and recharge the batteries. There are two batteries. Always charge one while using the other. Place the charger in a safe place where it can be plugged in. Battery should slide in easily. Do not force the battery into the monitor. Practice changing the battery. Act quickly for siren alerts. Press the response buttons. This alert signals that Life Vest has detected a life -threatening rapid heart rhythm. Only the patient should press the response button. If a treatment is received by the Life Vest, leave the Life Vest on and call the doctor. Call [NAME] for a new electrode belt, and check display for any messages and take action. Read the display for [NAME] alerts and follow the instructions on the screen. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When connecting and disconnecting the electrode belt be careful not to bend the pins. Remove the battery from the monitor before you remove the garment. Remove the electrode belt from the garment and insert it into a clean garment. Make sure the silver sides of the therapy pads (with the green label) face the mesh of the pocket. Snap the pockets closed. Position and secure the vibration box to the garment. Attach the round electrodes to the garment. Match the colors on the backs of the electrodes to the colors on the garment. Electrodes and therapy pads should press against bare skin. The mesh fabric pockets, and silver side of the therapy pads (with green labels) MUST TOUCH BODY for the device to work properly. Do not put the monitor, electrode belt, battery or charger in water; do not get components wet. Call [NAME] immediately if a Call for Service- Message Code 102 appears on the Life Vest screen. A replacement device will be provided within 24 hours from your notification to [NAME]. Wash the garment every 1-2 days. Do not use bleach or fabric softener. If prompted to download data, follow the instructions to do so. Review of Resident R314's clinical record revealed a Printable Discharge Form dated 2/12/25, that included correspondence between the facility and the discharging hospital, in which the hospital had documented, I was just told the patient has a life vest, she has it here. Will that be, okay? On 2/12/25, at 10:53 a.m. the facility responded, that is fine. Resident was accepted to facility and admitted later that day. Review of the clinical record indicated Resident R314 was admitted to the facility on [DATE]. Review of Resident R314's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and high blood pressure. During Resident R314's interview on 2/24/25, at 11:15 a.m. a charging station for Life Vest batteries was observed on the window ledge and resident confirmed that she was wearing a Life Vest. During an interview on 2/24/25, at 12:10 p.m. Nurse Aide (NA) Employee E3 stated, I'm not sure what a Life Vest is. If I'd see it maybe I'd know. During an interview on 2/24/25, at 12:15 p.m. NA Employee E4 stated, She came with it. The resident educated me on it. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/24/25, at 12:30 p.m. Licensed Practical Nurse (LPN) Employee E5 stated, This is the first time I've worked in this hallway. I've taken care of them before in the past. Nobody has educated me about Resident R314's Life Vest. We usually don't take Life Vest residents but sometimes they sneak in. During an interview on 2/24/25, at 12:45 p.m. Registered Nurse (RN) Employee E6 stated, What I recall is that you just have to keep the battery charged up, I think daily. When asked what the alarms on the Life Vest meant, RN Employee E6 stated, What alarms, I don't know. When asked if the NA are allowed to shower the resident, RN Employee E6 stated, I don't think so. When asked if staff are allowed to turn off the alarms, RN Employee E6 stated, I believe you can, you just have to go back and see what its saying. Review of Resident R314's care plan on 2/24/25, at 12:50 p.m. failed to reveal instructions for care and operation of Resident R314's Life Vest. Review of Resident R314's current orders on 2/24/25, at 12:55 p.m. failed to reveal a physician order for a Life Vest. Review of Resident R49's clinical record revealed a Printable Discharge Form dated 2/6/25, that included correspondence between the facility and the discharging hospital, that stated that Resident R49 will be getting a Life Vest on discharge. Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident R49's MDS dated [DATE], indicated diagnoses of high blood pressure, septicemia (an infection of the blood), and heart failure. Review of Resident R49's clinical record revealed a Nursing Progress note dated 2/10/25, that stated Life Vest intact. Review of Resident R49's clinical record conducted on 2/24/25, at 12:59 p.m. did not include orders, or care plan for a Life Vest. During an observation and interview on 2/24/25, at 2:03 p.m. in Resident R49's room, a charging station for Life Vest batteries was noted to be on the window ledge, which Resident R49 confirmed, and that he was indeed wearing a Life Vest which he had upon admission to the facility. During an interview on 2/24/25, at 2:11 p.m. NA Employee E10 stated that she has been educated on Life Vests before But not here. At my other job. During an interview on 2/24/25, at 2:13 p.m. RN Employee E11 stated that she did not receive any type of education on the safety and operation of the Life Vest. During an interview on 2/24/25, at 2:17 p.m. LPN Employee E12 stated that she had not received education on the Life Vest for Resident R49. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/24/25, at 2:20 p.m. NA Employee E13 stated that she was assigned to Resident R49 that day. When State Agency (SA) asked NA Employee E13 if she was aware that Resident R49 had a Life Vest, she replied A what?, and indicated that she was unaware of what that meant. When SA asked her if she was aware if Resident R49 could remove the Life Vest she replied That's information I wouldn't know. That would go to the nurses, not me. On 2/24/25, at 3:42 p.m. the Nursing Home Administrator (NHA) was made aware that Immediate Jeopardy (IJ) existed, NHA was provided the IJ Template, that placed two residents (Resident R314, and R49) in immediate jeopardy in which health and safety were impacted, and a corrective action plan was requested. During an interview on 2/24/25, at 3:42 p.m. the Director of Nursing (DON) stated We identified a second Life Vest that we didn't even know we had. The hospital just sends them to us and doesn't notify us. On 2/24/25, at 5:49 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action: - Clinical staff will complete education on the care and operation of Life Vests by 2/25/25, at 12:00 p.m. and before they work their next shift, that includes but is not limited to what the different alarms mean, the dangers of electrical shock, the care of the batteries, the care of the garment for laundering, and special needs for bathing. - The facility will demonstrate competency of all clinical staff through completion of a test following the education. Testing will be completed by 2/25/25, at 12:00 p.m. and before staff work their next shift. - A resident centered comprehensive care plan outlining the care of Resident R314, and R49 related to the Life Vest has been completed. - A care plan addressing the Life Vest, and the management of the Life Vest has been completed for Resident R314, and R49. - The facility obtained physician orders for the implementation of the Life Vest. - Clinical staff will be educated on the policies and procedures related to the use of the Life Vest and education will be confirmed by 2/25/25, at 12:00 p.m. and prior to staff working their next shift. Residents: - Resident R314's physician's orders and care plan were updated. - Resident R49's physician's orders and care plan were updated. System Correction: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The facility will produce a policy related to the Life Vest and will provide in an education to staff by 2/25/25, at 12:00 p.m. and prior to the start of their next shift. - The facility will provide a policy/procedure related to the admission of residents with anticipated equipment needs that will be provided to clinical staff and admissions team by 2/25/25, at 12:00 p.m. and prior to the start of their next shift. Monitoring: - Audits will be conducted of five clinical staff for one day beginning 2/25/25 to demonstrate competency of caring for a resident with a Life Vest. - Audits will continue to include five staff weekly to demonstrate competency of caring for a resident with a Life Vest for 2 weeks or until substantial compliance is achieved. - Education and initial audit results will be reviewed with the Quality Assurance and Quality Improvement Committee for analysis and further recommendation in a meeting conducted on 2/25/25. During an interview on 2/25/25, at 10:10 a.m. NA Employee E21 verified that she had received education on the Life Vest and stated, I never worked with one before, so it was helpful. During an interview on 2/25/25, at 10:12 a.m. RN Employee E22 also verified that she had received education on the Life Vest and stated that it was her first time that the facility had educated her on the topic. During an interview on 2/25/25, at 10:16 a.m. NA Employee E23 verified that she received education on the Life Vest and added Life Vest is all new to me. During an interview on 2/25/25, at 10:17 a.m. NA Employee E13 verified that she had received education on the Life Vest and stated I didn't know anything about it (prior to receiving the education). These are things that we should know. During a clinical record review on 2/25/25, at 10:45 a.m. Resident R314, and R49 had physician orders and care plans for Life Vest. Review of facility documents on 2/25/25, revealed that the facility had 136 clinical employees and that 131 had received Life Vest education. The remaining employees were to receive their education prior to the start of their next shift. 124 employees had received education on Life Vest and had been administered a written test to verify their knowledge. The remaining employees will take the test prior to the start of their next shift. During employee interviews on 2/25/25, from 10:05 a.m. through 1:30 p.m. 29 employees confirmed they had received education on the safe care, operation, and policies of the Life Vest as stated above. 26 of these employees had also completed a written test on Life Vest prior to the start of their next shift. Three employees verified that they had received the education at home but were to take the written test when they came into the facility prior to the start of their next shift. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility documents on 2/25/25, verified that a policy was produced for Life Vest and that policy was reviewed for the admission process of residents with anticipated equipment needs. Review of facility documents on 2/25/25, verified that audits were conducted for five clinical staff members to demonstrate competency of caring for a resident with a Life Vest. The Immediate Jeopardy was lifted on 2/25/25, at 1:49 p.m. when the action plan was verified. During an interview on 2/25/25, at 1:50 p.m. the NHA confirmed that the facility failed to ensure that nursing staff have the specific competencies, and skill sets necessary to provide care for a resident with a Life Vest, and placed two residents in immediate jeopardy in which health and safety were impacted (Resident R314, and R49). 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(a)(b)(1)(e)(1) Management. 28 Pa Code 201.29(a)Resident rights. 28 Pa Code 211.5(f) Clinical records. 28 Pa. Code: 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12(c)(d)(1)(2)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based upon review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that any irregularities submitted in the medication regimen reviews (MRR) by pharmacy were acted upon timely for one out of three residents (Resident R75). Findings include: Review of facility policy Medication Monitoring dated 1/2/25, indicated comments and recommendations concern drug therapy are communicated in a timely fashion. A summary of all recommendations is provided to the Director of Nursing and Facility Medical Director every month. The timing of these recommendations should enable a response prior to the next drug regimen review. The consultant pharmacist and the facility follows up on his/her recommendations to verify that appropriate action has been taken. Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE]. Review of Resident R75's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/25, indicated diagnoses of high blood pressure, Gastroesophageal Reflux Disease (GERD - when stomach acid frequently flows back into the esophagus), and hyperlipidemia (high levels of fat in the blood). Review of a physician order dated 2/28/24, indicated to administer Omeprazole (Prilosec) 40 mg (milligrams) by mouth one time a day for GERD. This order was discontinued on 12/23/24 and re-ordered on 1/7/25. During a review of Resident R75's clinical record on 2/25/25, the above order was active. Review of a MRR dated 4/25/24 indicated the following recommendations from the pharmacist to the physician: - Resident is currently receiving Clopidogrel (Plavix - a medication that prevents blood from clotting) and Prilosec. An FDA (The Food and Drug Administration) safety alert warns about a potential drug interaction between Clopidogrel and Prilosec, which may lead to decreased effectives ness of Plavix. Consider changing Prilosec 40 mg daily to Protonix 40 mg daily, which does not appear to interact with Plavix. Review of the MRR dated 4/25/24, indicated the physician agreed with the pharmacist's recommendation on 5/1/24. Review of a MRR dated 8/14/24, indicated the following recommendations from the pharmacist to the physician: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident is currently receiving Clopidogrel (Plavix - a medication that prevents blood from clotting) and Prilosec. An FDA safety alert warns about a potential drug interaction between Clopidogrel and Prilosec, which may lead to decreased effectives ness of Plavix. Consider changing Prilosec 40 mg daily to Protonix 40 mg daily, which does not appear to interact with Plavix. This recommendation was agreed to in April but no changes were made in the EMR (electronic medical record). Review of the MRR dated 8/14/24 revealed no response from the physician. The letter L was written below the signature line and no date was present. Review of a MRR dated 9/26/24, indicated the following recommendations from the pharmacist to the physician: - The Beer's Criteria (a set of evidence-based guidelines designed to help healthcare professionals identify and avoid potentially inappropriate medications in older adults) includes Proton Pump Inhibitors used for greater than 8 weeks as a potentially inappropriate medication except for high risk patients (e.g., chronic NSAID use), erosive esophagitis, Barrett's esophagitis, pathologic hypersecretory conditions, or a demonstrated need for maintenance therapy, due to an increased risk of C. difficile infection and bone loss fractures. This resident has been on Omeprazole 40 mg one time a day since 2/29/24. Considering tapering and discontinuing Omeprazole at this time or document the continued need based on the criteria listed above. Review of the MMR dated 9/26/24, indicated the physician agreed with the pharmacist's recommendation on 11/3/24. Review of a MRR dated 11/26/24, indicated the following recommendations from the pharmacist to the physician: - The Beer's Criteria includes Proton Pump Inhibitors used for greater than 8 weeks as a potentially inappropriate medication except for high risk patients (e.g., chronic NSAID use), erosive esophagitis, Barrett's esophagitis, pathologic hypersecretory conditions, or a demonstrated need for maintenance therapy, due to an increased risk of C. difficile infection and bone loss fractures. This resident has been on Omeprazole 40 mg one time a day since 2/29/24. Considering tapering and discontinuing Omeprazole at this time or document the continued need based on the criteria listed above. This recommendation was agreed to previously but no action was taken. Review of the MRR dated 11/26/24, indicated the physician agreed with the pharmacist's recommendation on 12/4/24. During an interview on 2/28/25, at 10:12 a.m. Corporate Clinical Coordinator Employee E7 stated, It looks like the physician agreed with the pharmacist's recommendations and just never wrote an order. During this interview Corporate Clinical Coordinator Employee E7 confirmed that the facility failed to ensure that any irregularities submitted in the medication regimen reviews by pharmacy were acted upon timely as required. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Clinical records. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(c)(d)(1)(2)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies in one of three medication carts (Ebensburg Second Hall Med Cart). Findings: Review of facility Medication Storage in facility policy dated [DATE], indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer ' s recommendations or those of the supplier. Narcotics are stored in a separate area under double lock. Expiration dates included: Humalog and Glargine Insulin expires 28 days after opened. During a medication cart review on [DATE], at 9:51 a.m. the narcotic lock box on the Ebensburg Second Hall medication cart was not locked. The medication cart also included: - Humalog Insulin Pen (used to treat diabetes - a metabolic disorder in which the body has high sugar levels for prolonged periods of time) that was expired. - Insulin Glargine Pen (used to treat diabetes) that did not have an opened date on it. During an interview on [DATE], at 9:53 a.m. Registered Nurse (RN) Employee E1 confirmed that the narcotic drawer was not locked and there was expired and undated insulin pens on the cart. During an interview on [DATE], at 3:00 p.m. the Director of Nursing confirmed that the facility failed to properly store medical supplies one of three medication carts (Ebensburg Second Hall Med Cart). 28 Pa Code: 211.9 (a)(1)(2) Pharmacy services. 28 Pa code: 211.12 (d)(1)(5) Nursing services.

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Concordia at Villa St Joseph	1030 State Street Baden, PA 15005

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46167 Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to ensure that nursing staff had the specific competencies and skill set necessary to provide care for residents with a Life Vest (a wearable defibrillator designed to protect residents from sudden cardiac death). Findings include: The signed job description for Nursing Home Administrator dated 1/31/19, indicated that this position leads a team of professionals and directs the daily operations of the facility in all departments to assure the provision of high-quality care/services making sure that the medical, physical, social, and emotional needs and general welfare of residents are met. The signed job description for Director of Nursing dated 1/2/19, indicated the purpose of this position is to plan, organize, develop, and direct the overall operation of the Nursing Service Department in accordance with current Federal, State, and local standards, guidelines, and regulations that govern the facility to assure the highest degree of quality care can be maintained at all times. Based on the findings in this report that identified that the facility failed to make certain that staff was adequately trained and had specific competencies and skill set necessary to provide quality care to residents who wear issued Life Vests. This failure created an immediate jeopardy situation for two of two residents (Resident R49 and R314). During an interview on 2/24/25, at 3:42 p.m. the NHA and DON confirmed they failed to effectively manage the facility to ensure that nursing staff had the specific competencies and skill set necessary to provide care for residents with a Life Vest. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on clinical record review, staff interviews and a review of the facility's assessment it was determined that the facility failed to implement and document a complete facility wide assessment, which identified the specific resources necessary to care for its specific resident population. Findings include: Review of the facility policy Facility Assessment, dated 1/2/25, indicated that the facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operation and emergencies. The facility's resident population, including but not limited to the staff competencies that are necessary to provide the level and types of care needed for the resident population. Review of clinical record revealed a Printable Discharge Form dated 2/6/25, that included correspondence between the facility and the discharging hospital, that stated that Resident R49 will be getting a Life Vest (a wearable defibrillator designed to protect from sudden cardiac death) on discharge. Review of the clinical record revealed that Resident R49 was admitted to the facility on [DATE]. Review of Resident R49s MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/16/25, indicated diagnoses of high blood pressure, septicemia (an infection of the blood), heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R49's clinical record revealed a Nursing Progress note dated 2/10/25, that stated Life Vest intact. During an observation and interview on 2/24/25, at 2:03 p.m. in Resident R49's room, a charging station for Life Vest batteries was noted to be on the window ledge, which Resident R49 confirmed, and that he was indeed wearing a Life Vest which he had upon admission to the facility. Review of Resident R314's clinical record revealed a Printable Discharge Form dated 2/12/25, that included correspondence between the facility and the discharging hospital, in which the hospital had documented, I was just told the patient has a life vest, she has it here. Will that be, okay? On 2/12/25, at 10:53 a.m. the facility responded, that is fine. Resident was accepted to facility and admitted later that day. Review of the clinical record indicated Resident R314 was admitted to the facility on [DATE]. Review of Resident R314's MDS dated [DATE], indicated diagnoses of heart failure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and high blood pressure. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During Resident R314's interview on 2/24/25, at 11:15 a.m. a charging station for Life Vest batteries was observed on the window ledge and resident confirmed that she was wearing a Life Vest. Review of the Facility assessment dated [DATE], failed to include the use of a Life Vest as a condition that requires complex medical care and management routinely cared for in the facility. Interview on 2/25/25, at 12:06 p.m. the Nursing Home Administrator confirmed the facility failed to implement and document a complete facility wide assessment, which identified the specific resources necessary to care for its specific resident population. 201.14(a) Responsibility of Licensee. 201.18(b)(1) Management.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to identify a hospice provider in physician orders and failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for two of three residents (Residents R59 and R90). Finding include: Review of facility policy Hospice Services Facility Agreement dated 1/2/25, indicated a facility designee will work with the hospice representative and is responsible for obtaining physician certification and recertification of the terminal illness specific to each resident and instructions on how to access the hospice's 24-hour on-call system. The facility will, under a written agreement, ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the clinical record indicated Resident R59 was admitted to the facility on [DATE]. Review of Resident R59's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/17/24, indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), malnutrition (lack of sufficient nutrients in the body), and depression (a constant feeling of sadness and loss of interest). Review of Section O, Question O0110K1 indicated the resident received hospice care while in the facility. Review of a physician order dated 8/3/23, indicated to admit the resident to hospice services with a diagnosis of Alzheimer's Disease. Review of Resident R59's comprehensive care plan on 2/27/25, failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 2/28/25, at 10:12 a.m. Corporate Clinical Coordinator Employee E7 confirmed that the facility failed to ensure the coordination of hospice services with the facility services to meet the needs of Resident R59. Review of the clinical record indicated Resident R90 was admitted to the facility on [DATE]. Review of Resident R90's MDS dated [DATE], indicated diagnoses of cancer (uncontrolled growth and spread of abnormal cells), high blood pressure, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section O, Question O0110K1 indicated the resident received hospice care while in the facility. Review of a physician order, indicated to consult hospice and hospice diagnoses of malignant neoplasm of bone and face (cancer). Physician orders failed to identify a hospice provider. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R90's comprehensive care plan on 2/27/25, failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 2/27/25, at 9:46 a.m. Director of Nursing confirmed that the facility failed to identify a hospice provider in physician orders and failed to ensure the coordination of hospice services with the facility services to meet the needs of Resident R90. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement infection control practices to prevent cross contamination during a dressing change for one of two residents (Resident R8). Findings include: The Centers for Disease Control defines Enhanced Barrier Precautions (EBP) as: an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP involve gown and gloves during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of the facility policy Enhanced Barrier Precautions Procedure dated 1/2/25, indicated the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refer to the use of gown and gloves for use during high-contact resident care activities for residents for example residents with wounds or indwelling medical devices. Review of the facility policy Wound Treatment Management dated 1/2/25, indicated to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/11/24, indicated diagnoses of coronary artery disease (CAD- arteries can't deliver enough oxygen to the heart), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Section M0210 Unhealed pressure ulcer/injury is coded as a 1, yes. Review of a physician order dated 2/19/25, indicated to cleanse right heel with normal saline solution (a solution of water and salt), apply Santyl (a chemical agent for removing dead skin cells) nickel thick with Mesalt (a medicated piece of gauze), apply calcium alginate (a soft medicated piece of gauze), cover with ABD pad (a gauze pad), wrap with Kerlix (a gauze bandage roll), and secure with tape every day and as needed. Review of a physician order dated 1/15/25, indicated EBP ordered every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation on 2/26/25, at 1:28 p.m. Licensed Practical Nurse (LPN) Employee E2 washed her hands, put gloves on, cleaned the surface of a stand at the foot of the bed, washed hands, laid a clean barrier on a stand at the foot of the bed, washed hands, put gloves on, placed barrier under foot, washed hands, put gloves on, opened supplies onto the barrier, removed wound scissors from package and cut bandage off residents foot, washed hands, put gloves on, cleansed area of wound, washed hands, put gloves on, applied the wound care, washed hands, put gloves on, wrapped the foot and placed tape to secure dressing, tape dated and initialed prior to putting on dressing, gathered supplies and disposed of appropriately, washed hands. During an interview completed on 2/26/25, at 2:05 p.m. LPN Employee E2 confirmed she failed to implement infection control practices to prevent cross contamination during a dressing change for Resident R8 by completing the wound care without the use of a gown and not cleaning the surface of the stand used after dressing was completed. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(d)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 48546 Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for three of three crash carts. Findings include: During an observation of the Ebensburg crash cart (a cart maintained with equipment used in cardiac emergencies) on 2/27/25, at 9:58 a.m. revealed a clipboard on the crash cart containing a Crash Cart Check List for February 2025. Review of the check list sheet documentation failed to reveal that the cart was checked on 2/11/25, and 2/15/25. During an interview on 2/27/25, Licensed Practical Nurse (LPN) Employee E9 confirmed the above observation. During an observation of the Fontbonne crash cart on 2/27/25, at 10:09 a.m. revealed a clipboard on the crash cart containing a Crash Cart Check List for February 2025. Review of the check list sheet documentation failed to reveal that the cart was checked on 2/5/25, 2/6/25, and 2/19/25. During an interview on 2/27/25, at 10:11 a.m. Registered Nurse (RN) Employee E8 confirmed the above observation. During an observation of the Carondelet crash cart on 2/27/25, at 10:15 a.m. revealed a clipboard on the crash cart containing a Crash Cart Check List for February 2025. Review of the check list sheet documentation failed to reveal that the cart was checked on 2/18/25, 2/23/25, and 2/24/25. Further review of the cart revealed a bag valve mask (a handheld device that delivers ventilation to patients who are not breathing) with an expiration date of 11/13/23. During an interview on 2/27/25, at 10:17 a.m. LPN Employee E9 confirmed the above observations. During an interview on 2/27/25, at 2:55 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that equipment was in safe operating condition for three of three crash carts as required. 28 Pa Code: 201.14(a) Responsibility of licensee.