STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396056	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William Penn Care Center	2020 Ader Road Jeannette, PA 15644

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785 Based on review of facility policies, resident clinical records, documentation provided by the facility, facility investigation, personnel records, family and staff interviews, it was determined that the facility failed to ensure that a resident was free from neglect, which resulted in actual harm as evidenced by right tibia (the anterior of two bones below the knee) fractures for one out of three residents (Resident R27). Findings include: The facility Safe resident handling/transfer policy dated 1/30/24, indicated that the facility will ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide a safe, secure, and comfortable experience. Mechanical lifts may include equipment such as full body lifts, sit to stand lifts (a mechanical device used to transfer resident. Device is typically placed in front of the resident with staff assistance), or ceiling tracked mounted lifts. Two staff members must be utilized when transferring residents with a mechanical lift. The facility Abuse, neglect and exploitation policy dated 4/6/23, last reviewed 1/30/24, indicated that the facility will provide protections for the health, welfare and rights of each resident by implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation. Neglect means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of Resident R27's admission record indicated she was originally admitted on [DATE], and readmitted on [DATE]. Review of Resident R27's MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 5/21/24, indicated she had diagnoses that included a history of falling, chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness), artificial hip joint, history of other fracture, and hyperlipidemia (elevated lipid levels within the blood). Section GG0170-Mobility/ bed-to-chair transfers indicated a 1-Dependent: the assistance of two or more helpers is required for the resident. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Review of Resident R27's care plans dated 5/24/24, indicated that Resident R27 required a Sit-to-Stand Machine with assistance of two staff for transfers.

Review of Resident R27's physician orders 6/20/23, indicated to transfer Resident R27 with sit-to-stand and assistance of two staff persons.

Review of Resident R27's physician order dated 7/17/24, indicated to X-ray her right lower leg.

Review of Resident R27's Kardex (electronic report detailing care and transfer status of resident) dated 7/18/24, indicated to transfer Resident R27 with sit-to-stand with assistance of two staff persons.

Review of Resident R27's physical therapy discharge assessment dated [DATE], indicated and recommended to continued use of sit-to-stand lift for functional transfers.

Documentation provided by the facility dated 7/17/24, indicated the following: on 7/17/24, Resident R27 was being transferred from the bed to the chair by two nurse aide staff members. Resident R27 was stood for transfer and put into the chair. Resident was to be an assist of two with a sit-to-stand lift. Registered Nurse (RN) Assistant Director of Nursing (ADON) Employee E11 went to see Resident R27 and found a bruise measuring 15cm x 13cm purple area on her right shin. Resident R27 did not remember bumping her leg. Doctor and family notified of area. Order for X-ray obtained to rule out any injury.

Review of Resident R27's clinical progress notes dated 7/17/24, indicated that the Registered Nurse (RN) Assistant Director of Nursing (ADON) Employee E11 was called to Resident R27's room. She was observed with discoloration noted to right lower extremity shin to side of inner calf measuring 15cm x 13cm. Resident R27 did complain of discomfort when touching area, not on movement. Spoke to her daughter and notified her of area. Doctor notified with new orders obtained: physician order dated 7/17/24, indicated to X-ray her right lower leg.

Review of incident report dated 7/17/24, indicated that Resident R27 gave the following statement:

Two girls (Nurse Aide (NA) Employee E13 and Agency Nurse Aide (NA) Employee E14) lifted Resident R27 up, one on each side of her and stood Resident R27 up. They could not find the lift this morning, so the two girls lifted her up.

Review of incident report signed and dated 7/17/24, Nurse Aide (NA) Employee E13 stated: I was searching for a sit-to-stand. Agency Nurse Aide (NA) Employee E14 told me we could do a two-person assist to transfer.

Review of facility X-ray of Resident R27 right leg dated 7/17/24, indicated she had an acute to sub-acute proximal right tibial fracture.

Review of Resident R27's clinical progress note dated 7/18/24, at 7:04 a.m. indicated her physician was made aware of X-ray results. Physician initially discussed an orthopedic consult as an outpatient, but he felt that she may see orthopedic quicker if she goes to the emergency room . Physician order was obtained to send to emergency room for evaluation.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R27's clinical progress note dated 7/18/24, at 8:53 a.m. Resident R27 left facility via ambulance to hospital. Review of Resident R27's hospital MRI report dated 7/18/24, indicated she had a non-displaced comminuted proximal tibial fracture of right medial tibial plateau (the top of the two shin-bones, under the knee cap) and tibial spine (the anterior of two bones below the knee). Review of Resident R27's clinical progress note dated 7/18/24, at 4:52 p.m. indicated she returned on 7/18/24 from the Hospital where she was sent for post fall injury to right leg. Report from hospital reports that the MRI showed a fracture of proximal end of tibia, as well a tibial plateau fracture. Resident R27 was put in a long-leg splint (velcro wrapping to secure leg) today and will need follow-up. Review of Nurse Aide (NA) Employee E13 personnel records indicated she was hired 3/7/24, she was trained on safety and transferring residents during orientation, and she was trained on neglect. Review of Agency Nurse Aide (NA) Employee E14 personnel records indicated she was hired 1/3/24, she was trained on safety and transferring residents, and she was trained on neglect. During an interview on 7/18/24, at 9:44 a.m. Registered Nurse (RN) Assistant Director of Nursing (ADON) Employee E11 stated: Resident R27 is out to the hospital. We got an X-ray of her right leg. She has a acute fracture to her tibia. During an interview on 7/18/24, at 9:48 a.m. Resident R27's Family RF stated the following: As far as the care Resident R27 gets daily, its amazing. Other than what happened, I'm pleased with her care. She has specific favorite aides. She never had an injury before. I was told that one aide was on each side and that this is how they got her out of the bed yesterday. Registered Nurse (RN) Assistant Director of Nursing (ADON) Employee E11 told me that staff did not use a lift as there was not a lift available. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/18/24, at 10:10 a.m. (RN) Assistant Director of Nursing (ADON) Employee E11 stated: Yesterday, I do not recall the time, but there is a note. I was called to the Resident R27's room. One of the nurse aides, Nurse Aide (NA) Employee E12, told me there was bruise. Nurse Aide (NA) Employee E12 asked me to come back. I saw the bruise, on the right lower extremity and on the shin area. I asked Agency Nurse Aide (NA) Employee E14 what happened as it looked to me that it was from the sit-to-stand lift. I asked the Resident R27 if the bruise was from the lift. It started to progress. It did not look that big and it was starting to swell. As I asked her questions, Resident R27 stated the two girls lifted her up and she said they could not find the lift. after I got her full statement, she said they stood her up, one on each side. She said her pants were rolled down below her knee. She was moving from bed to the chair. Resident R27 said she took a step and she felt her knee buckle. I reviewed the order after she said the lift was not involved. I looked at the assignment sheet. I saw that Nurse Aide (NA) Employee E13 was assigned. Agency Nurse Aide (NA) Employee E14 went in to assist Nurse Aide (NA) Employee E13. I asked them how Resident R27 was transferred, Agency Nurse Aide (NA) Employee E14 said no. the order was a stand-up lift or two-person assist. But the order does not say stand-up lift or two-person assist. It says to use the sit-to-stand lift. I had everyone write the statements. From what I understand. the aides are trained. Transfer information is available in the Kardex in their tasks. Nurse Aide (NA) Employee E13, came in at 10:00 a.m. yesterday. They are not her usual assigned aides. The regular aides pretty much know everyone. They should have known her transfer status and they know to look at the orders before doing a transfer. And there were three sit-to-stands over there and they said they could not find one. During an interview on 7/18/24, at 10:55 a.m. the Director of Rehabilitation Employee E15 stated: I am familiar with Resident R27. She was just on Occupational therapy recently, but not for transfers. She was discharged on [DATE]. There were no changes to the use of a sit-to-stand lift. She was discharged from Physical therapy on 2/7/23. The recommendation was to use sit to stand lift for transfers. During an interview on 7/18/24, at 11:03 a.m. Nurse Aide (NA) Employee E13 stated the following: yes, I knew Resident R27 had to be gotten up with a sit to stand. I was not able to find one. My coworker (Agency Nurse Aide (NA) Employee E14) told me she was a sit to stand and a two-person assist as well. We did a two-person assist with her. She was moved from bed to chair transfer. We sat Resident R27 down and Resident R27 stated her leg was bothering her. We should have looked at her leg. Agency Nurse Aide (NA) Employee E14 told me she would report it to the nurse. I believe when I left the room, we started passing trays. I have never had anything like this happen before. I am very remorseful and sorry. I would never hurt anyone, especially the residents. This occurred between 10:30 a.m. and 11:00 a.m. Staff can find information about transfer status in the care plan. I did not look at the information before moving Resident R27. I just went by Agency Nurse Aide (NA) Employee E14 word. I was trained on using sit-to-stand and reviewing the care plan or Kardex before transfer. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/18/24, at 11:11 a.m. Agency Nurse Aide (NA) Employee E14 stated the following: I did not have Resident R27 section yesterday. I do have it sometimes. I was asked for help to transfer her. I was asked by Nurse Aide (NA) Employee E13 to transfer Resident R27. We went into Resident R27 room. Resident R27 complained about her leg hurting before we moved her from the bed. We did not check or anything if there was a problem. We lifted her from her bed to her chair. I touched her leg. and then that was it, and I went back to her residents. I told them that we two-person assisted her. I thought it was two-person assist or sit to stand. I went back and looked. I was wrong for not using the sit-to-stand. I was also wrong for not questioning if we could use the sit-to-stand. I was wrong and I am not going to say I did not do something wrong: I did. When you have a good bit of residents and you are trying to get your own work done. I am always the first to help. It was my negligence to not do the right thing. I would never hurt or do something wrong to endanger them. This occurred around 10:30 a.m. I know I was going into another resident room. and right after that I was right back in another resident room. it was less then two minutes. The transfer status information is in the charting. it asks about the transfer and if the procedure was followed. I did not review information prior to moving resident, when I charted on the patient before. I just assumed. I did not know it read sit to stand with 2-assist, because Resident R27 can stand with two staff persons present. I was trained on using sit to stand through my agency and I had orientation and training in the past. I had courses with using sit-to stand, Hoyer lift and sliding board. During an interview on 7/18/24, at 11:30 a.m. Nurse Aide (NA) Employee E12, nurse aide stated the following: Resident R27 was in my care yesterday. I had another aide, Nurse Aide (NA) Employee E13, bed bath her and get her up. Nurse Aide (NA) Employee E13 and Agency Nurse Aide (NA) Employee E14 got her up. After lunch, Resident R27 rang her call bell to lay back down. I went into the room. Nurse Aide (NA) Employee E13 and Agency Nurse Aide (NA) Employee E14 were laying her down. When we took her ted hose off, we saw the bruise on her leg. It was about soft ball size bruise. Resident R27 said her right leg was hurting. We went out and got the nurse that was in the hall. Resident R27 stated her leg started to hurt when they got her out of bed. Information found related to transfers is in the charting. Staff are all trained on using the sit to stand and Hoyer lift. If an aide does not know transfer status they should ask a nurse, and if they do not know, look in the charting. During an interview on 7/18/24, at 11:46 a.m. Nurse Aide (NA) Employee E16 stated that she was trained on use of sit to stand, two staff help residents with sit to stand lifts, transfer information for residents is found in the Kardex, and if staff you don't know the transfer status, they will go find out first by looking at the Kardex. During an interview on 7/18/24, at 11:53 a.m. Nurse Aide (NA) Employee E17 stated that she was trained on use of sit to stand, two staff help residents with sit to stand lifts, information found related to resident transfers is in the charting on the electronic kiosk and in the Kardex, and if staff don't know the transfer status to look at the Kardex. During an interview on 7/18/24, at 2:06 p.m. Licensed Practical Nurse (LPN) Employee E6 stated that she was trained on use of sit-to-stand, transfer information for residents is found in the ADL (activity of daily living) in the computer for status, two staff help residents with any mechanical lift, and if staff don't know the transfer status to speak with her as she is familiar with Resident R27. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/19/24, at 9:15 a.m. Registered Nurse (RN) Assistant Director of Nursing (ADON) Employee E11 stated: Resident R27 came back yesterday. She currently has a splint to her right leg. Orthopedic consultant was considering her getting a cast. During an interview on 7/19/24, at 9:19 a.m. Licensed Practical Nurse (LPN) Employee E18 stated she was trained on use of sit to stand, transfer information for residents is usually found in the Physican's orders, staff discuss status during report in the morning. She stated that if staff don't know the transfer status to staff and look on morning report. Never assume. Two staff persons are used for using mechanical lift. And she was familiar with Resident R27 and Resident R27 usually uses a sit-to-stand to transfer. During an interview on 7/19/24, at 9:21 a.m. Nurse Aide (NA) Employee E19 stated that she was trained on use of sit-to-stand, two staff help residents with sit to stand lifts, information found related to resident transfers is in the charting on the electronic kiosk and in the Kardex, and she was familiar with Resident R27 and Resident R27 usually uses a sit-to-stand to transfer. During an interview on 7/19/24, at 11:12 a.m. the Director of Nursing (DON) confirmed that the facility failed to ensure that Resident R27 was free from neglect as required, which resulted in actual harm as evidenced by right tibia fractures. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of clinical records and facility provided documents, and staff interviews, it was determined that the facility failed to ensure that residents were free from misappropriation (the act of stealing something that you have been trusted to care of and using it for yourself) of $5,251.83 for one of three residents reviewed (Resident R5). Findings include: Review of the facility policy Abuse dated 1/30/24, indicated each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Review of admission record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS- a periodic assessment of care needs) dated 6/4/24, indicated the diagnoses of high blood pressure, renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and heart failure (heart doesn't pump blood as well as it should). Review of facility provided documentation dated 12/13/23, at 4:00 p.m. indicated during the week of 9/25/23, Resident R5's daughter reported that $5,251.83 in cash was given to the previous Business Officer Manager (BOM) Employee E8 and was not showing up in her mother's resident trust account. There was a receipt written but no deposit in the resident trust was completed. Money was not located in the facility's safe. Further review of the facility provided documentation dated 12/13/23, at 4:00 p.m. indicated after a lengthy investigation and multiple attempts to reach BOM Employee E8, the facility was unable locate the money or the employee and reported findings to the police. Interview on 7/19/24, at 10:00 a.m. the Nursing Home Administrator confirmed the facility failed to ensure that residents were free from misappropriation of $5,251.83 for one of three residents reviewed (Resident R5). 28 Pa Code: 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation of property of residents for one of three residents reviewed (Closed Record Resident CR1). Findings include: Review of the facility policy Abuse dated 1/30/24, indicated - Protection: the facility will take all reasonable measures to ensure protection of the resident during an abuse investigation from any possible existing threat. In the event that the alleged perpetrator is an employee, that employee will be suspended pending investigation outcome or police intervention. Review of the admission record indicated Resident CR1 was admitted to the facility on [DATE]. Review of Resident CR1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/5/24, indicated the diagnoses of high blood pressure, renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and atrial fibrillation (irregular heart rhythm). Review of facility provided documentation dated 6/18/24, at 12:00 p.m. indicated the facility was contacted by local police on/or around 6/18/24, regarding Nurse Aide (NA) Employee E9, that they were investigating her for the possible theft of around $18,000 - $20,000 dollars from Resident CR1 who resided at the facility until 3/6/24. Interview on 7/17/24, at 1:30 p.m. Human Resource Employee E10 indicated that Nurse Aide (NA) Employee E9 has been working in the facility and was not suspended or separated from residents as required. Interview on 7/17/24, at 2:12 p.m. the Nursing Home Administrator confirmed that the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and misappropriation of property of residents for one of three residents reviewed (Closed Record Resident CR1). 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)(j) Resident rights.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, facility provided documents, resident, and staff interviews, it was determined that the facility failed to report an alleged allegation of misappropriation of property for one of three residents (Resident CR1). Findings include: Review of the facility's policy Abuse dated 1/30/24, indicated any reasonable suspicion of a crime committed against a resident of the facility will be reported to the Department of Health and at least one law enforcement entity. If the event that caused the suspicion did not result in serious bodily injury the facility will report the suspicion within 24 hours after forming the suspicion. Review of the admission record indicated Resident CR1 was admitted to the facility on [DATE]. Review of Resident CR1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/5/24, indicated the diagnoses of high blood pressure, renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and atrial fibrillation (irregular heart rhythm). Review of facility provided documentation dated 6/18/24, at 12:00 p.m. indicated the facility was contacted by local police on/or around 6/18/24, regarding Nurse Aide (NA) Employee E9, that they were investigating her for the possible theft of around $18,000 - $20,000 dollars from Resident CR1 who resided at the facility until 3/6/24. Review of State reportable abuse allegations dated 8/27/23 to 7/11/24, did not include a facility report related to Resident CR1's allegations of misappropriation. Interview with the Nursing Home Administrator on 7/17/24, at 2:12 p.m. indicated the there was no report to the local State field office and confirmed the facility failed to report an alleged allegation of misappropriation of property for one of three residents (Resident CR1). 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)(j) Resident rights.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, facility provided documents, and staff interview, it was determined that the facility failed to investigate a potential allegation of abuse/neglect for misappropriation of property for one of three residents (Closed Record Resident CR1). Findings include: Review of the facility's Abuse policy dated 1/30/24, indicated all allegations of abuse, neglect, exploitation, or mistreatment of residents will be thoroughly investigated by the administrator and support staff. Review of the admission record indicated Resident CR1 was admitted to the facility on [DATE]. Review of Resident CR1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/5/24, indicated the diagnoses of high blood pressure, renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), and atrial fibrillation (irregular heart rhythm). Review of facility provided documentation dated 6/18/24, at 12:00 p.m. indicated the facility was contacted by local police on/or around 6/18/24, regarding Nurse Aide (NA) Employee E9, that they were investigating her for the possible theft of around $18,000 - $20,000 dollars from Resident CR1 who resided at the facility until 3/6/24. Interview on 7/17/24, at 2:12 p.m. the Nursing Home Administrator indicated the facility did not initiate an investigation into the allegation of misappropriation of property received on 6/18/24, and that the facility failed to investigate a potential allegation of abuse/neglect for misappropriation of property for one of three residents (Closed Record Resident CR1). 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)(j) Resident rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER William Penn Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 Ader Road Jeannette, PA 15644	

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on review of facility policy, resident records, admission documentation and staff interview, it was determined that the facility failed to maintain admission documentation for two of three residents (Resident R2, R60). Findings include: The facility Admissions policy last reviewed 1/30/24, indicates the facility will maintain an admissions policy governing admissions to the facility to ensure fair and impartial admisssion practices. Review of Resident R60 was admitted [DATE] with diagnoses that include dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cardiomegaly(enlargement of the heart) and chronic kidney disease. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R60 Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 4/8/22 indicated the resident was assessed as having a BIMS score of 7, which indicates severe cognitive impairment. Review of Resident R60's admission packet dated 4/6/22 indicated a signature from R60. Review of Resident R2 was admitted [DATE] with diagnoses that include chronic kidney disease and hypertensive heart disease (changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation). Review of Resident R2 Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 11/4/23 indicated the resident was assessed as having a BIMS score of 2, which indicates severe cognitive impairment. Review of Resident R2's admission packet dated 11/16/23 indicated a signature from R2. During an interview with Admission Coordinator Employee E25 on 7/18/24 at 11:30 a.m. confirmed Resident R2 & R60 were cognitivly impaired and should not have signed facility paperwork. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code: 201.18(b)(2) Management 28 Pa Code: 201.24(a) Admission policy 28 Pa Code: 201.19(i) Residents rights

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two out of two residents sampled with facility-initiated transfers (Residents R67, and R72). Findings include: Review of the facility policy Transfer or Discharge, Emergency dated 1/30/24, indicated that should it become necessary to make an emergency transfer or discharge to a hospital the facility will prepare a transfer form to send with the resident. Review of the clinical record indicated Resident R67 was admitted to the facility on [DATE]. Review of Resident R67's MDS dated [DATE], indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), cerebral vascular accident (an interruption in the flow of blood to cells of the brain), and dysphagia (difficulty swallowing). Review of Resident 67's clinical record revealed that the resident was transferred to the hospital on 5/13/24, and returned to the facility on [DATE]. Review of Resident R67's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R72 was admitted to the facility on [DATE]. Review of Resident R72's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), and hearing loss. Review of Resident R72's clinical record revealed that the resident was transferred to the hospital on 3/4/24, and returned to the facility on [DATE]. Review of Resident R72's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/18/24, at 12:21 p.m. the Director of Nursing confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for two out of two residents sampled with facility-initiated transfers (Residents R67, and R72). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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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 35785

Based on review of facility policy, clinical records, observations, resident and staff interview it was determined that the facility failed to provide care as per physician's order and failed to provide weekly assessments for one out of four sampled residents with a surgical area (Resident R74).

Findings include:

The facility Negative pressure wound therapy policy dated 1/30/24, indicated that to promote wound healing, the facility will provide evidence-based treatments in accordance with current standards of practice and physician orders. Negative pressure wound therapy is an active wound care treatment that uses controlled sub-atmospheric (negative) pressure to assist and accelerate healing. The therapy will be provided in accordance with physician orders, including the desired pressure settings, continuous or intermittent therapy, and frequency of dressing change. Monitoring throughout the use of negative pressure wound therapy shall include pain, device functioning, settings, and response to therapy including the wound characteristics.

Review of Resident R74's admission record indicated he was admitted on [DATE], and readmitted on [DATE].

Review of Resident R74's MDS (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 7/9/24, indicated he had diagnoses that included a history of falling, displaced trimalleolar fracture (fracture of the left ankle), hypertension (a condition impacting blood circulation through the heart related to poor pressure), dislocation to the left tarsometatarsal joint (joints in the middle of the foot), insertion of left artificial ankle joint, and an infection.

Review of Resident R74's hospital records dated 6/24/24, indicated that Resident R74 was hospitalized due to infection to left ankle surgical area. Hospital ordered use of wound vacuum, and his left surgical area measured 5 cm (centimeter) x 2cm x 2cm.

Review of Resident R74's physician orders dated 7/15/24, indicated to apply wound vacuum and change dressing every Monday, Wednesday, and Friday. Apply to incisional vacuum to lateral incision. No need to place wound vac to medial incision. Apply Seattle Splint. Resident R74 is non-weight bearing to left lower extremity.

Review of Resident R74's physician orders did not include actions to take if the wound vacuum was inoperable or equipment was unavailable.

Review of Resident R74's skin/wound note dated 7/3/24, indicated that Resident R74 has surgical area to left lower extremity and will assess wound next week after appointment.

Review of Resident R74's skin/wound notes dated 7/4/24 to 7/16/24 did not include an assessment of the left surgical wound area.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24, at 10:19 a.m. Registered Nurse (RN) Employee E5 confirmed that the facility did not put in an order for a wet-to-dry dressing change in the event the wound vacuum should malfunction. During an interview on 7/16/24, at 10:19 a.m. Registered Nurse (RN) Employee E5 stated: nursing staff can change the wound vacuum dressing for Resident R74. When he went to an orthopedic appointment, he was found with an infection to the left ankle and massive amount of drainage. During observations on 7/16/24, at 12:46 p.m. Resident R74's wound vacuum was found on his left surgical area, but the wound vacuum machine was observed off. During an interview on 7/16/24, at 12:47 p.m. the Assistant Director of Nursing (ADON) Employee E7 stated The wound vacuum machine is not on. It may have been shut off during therapy. During an interview on 7/16/24, at 12:48 p.m. Resident R74 stated I've been in my room and back from therapy for about an hour. During an interview on 7/17/24, at 2:49 p.m. the Director of Nursing (DON) confirmed that the facility failed to provide care as per physician's order and failed to provide weekly assessments for Resident R74 surgical area as required. 28 Pa Code: 201.14 (a) Responsibility of licensee 28 Pa Code 201.18 (b)(1)(3) Management 28 Pa Code 211.10(c) Resident care policies. 28 Pa Code 211.12 (a)(d)(1)(2)(3)(5) Nursing Services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on a review of the facility policy, clinical record review and staff interview, it was determined that the facility failed to assess the nutritional status of three of six residents (Resident R3, R35, and R67) records reviewed. Findings include: Review of facility's policy Role Delineation for Certified Dietary Manger, dated 1-30-24, indicated that the Certified Dietary Manager (CDM) may write progress notes by stating factual information such as diet order, percent of food intake, as noted by nursing, height, weight, usual body weight, lab values, medications, etc. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/8/24, indicated diagnoses of high blood pressure, hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there), and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). Section K0200 question A and B indicated that resident was 65 inches tall, and weighed 173 pounds. Section K0520 question C and D indicated that Resident R3 had received a mechanically altered and therapeutic diet. Review of Resident R3's medical record revealed a Dietary Clinical note dated 5/9/24, that failed to include the height, weight, and diet captured by the MDS dated [DATE]. Review of the clinical record indicated Resident R67 was admitted to the facility on [DATE]. Review of Resident R67's MDS dated [DATE], indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), cerebral vascular accident (an interruption in the flow of blood to cells of the brain), and dysphagia (difficulty swallowing). Section K0200 question A and B indicated that Resident R 67 was 65 inches tall, and weighed 169 pounds. Section K0520 question D indicated that Resident R 67 had received a therapeutic diet. Review of Resident R67's medical record revealed a Dietary Clinical note dated 5/28/24, that failed to include the height, weight, and diet captured by the MDS dated [DATE]. During an interview on 7/17/24, at 12:55 p.m. Dietary Manger Employee E1 confirmed that the 5/9/24 Dietary Clinical Note for Resident R3, and 5/28/24, Dietary Clinical Note for Resident R67, did not contain information provided in the MDS dated [DATE], and 5/24/24, such as height, weight , and diet order, and that she was told to just put in a quick blurb. Review of R35's admission record indicated that she was admitted to the facility 12/22/23. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R35 's MDS dated [DATE], indicated diagnoses of chronic respiratory failure with hypercapnia(too much carbon dioxide in the blood) and pulmonary hypertension (condition in which a blood vessel in the lung(s) gets blocked by a blood clot). Review of Resident R35's MDS list indicates 12/28/23 Significant Change Assessment, 3/26/24 Quarterly Assessment and 6/26/24 Quarterly Assessment were completed. Review of Resident R35' clinical assessment summary indicated no Nutrional Assessment's on 3/26/24 and 6/26/24. During an interview on 7/17/24 at 12:50 p.m., Certified Dietary Manager confirmed she did not nutritionally assess Resident R35. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(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** 46336 Based on review of facility policies, observations, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate care of respiratory equipment for two of four residents (Residents R70 and R71). Findings include: Review of the facility policy Replacement and Maintenance of Respiratory Equipment dated 1/30/24, indicated on Mondays all nasal cannulas (a thin tube in the nostrils to deliver oxygen supplementation) will be labeled with the date issued every fourteen days. Review of the clinical record indicated that Resident R70 was admitted to the facility on [DATE]. Review of Resident R70's Minimum Data Set (MDS - periodic assessment of care needs) dated 7/3/24, indicated diagnoses of high blood pressure, obstructive sleep apnea (intermittent airflow blockage during sleep), and insomnia. Review of Resident R70's physician's order dated 7/7/25 indicated to administer CPAP (continuous positive airway pressure- a respiratory therapy intervention used to help people breathe during sleep) at home setting every night shift. During an observation on 7/15/24, at 1:08 p.m. Resident R70's CPAP mask was noted to be sitting on top of the nightstand. The storage bag was noted to be on the nightstand, however the CPAP mask was not being stored in the bag to prevent contamination. During an interview on 7/15/24, at 2:19 p.m. Registered Nurse (RN) Employee E3 confirmed that the CPAP mask should be stored in the storage bag, but that the facility failed to properly store Resident R70's CPAP mask. Review of the clinical record indicated that Resident R71 was admitted to the facility on [DATE]. Review of Resident R71's MDS dated [DATE], indicated diagnoses of hypertension (high blood pressure), obstructive sleep apnea, and depression. Review of Resident R71's physician's order dated 6/26/24, indicated to change nasal cannula every two weeks and oxygen at two liters/minute through nasal cannula at bedtime. During an observation on 7/15/24, at 11:27 a.m., Resident R71's nasal cannula failed to have a label with the date issued. During an interview on 7/15/24, at 11:29 a.m. Licensed Practical Nurse (LPN) Employee E6 confirmed Resident R71's nasal cannula failed to have a label with the date issued as required. Interview on 7/19/24, at 12:30 p.m. the Director of Nursing confirmed the facility failed to provide appropriate care of respiratory equipment for two of four residents (Residents R70 and R71). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2)(3)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of two residents (Resident R1, and R67). Findings include: Review of facility policy Trauma Informed Care dated 1/30/24, indicated that nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. Caregivers are taught strategies to help eliminate, mitigate or sensitively address resident's triggers. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/13/24, indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), high blood pressure, and dysphagia (difficulty swallowing). Review of Resident R1's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them. Review of the clinical record indicated Resident R67 was admitted to the facility on [DATE]. Review of Resident R67's MDS dated [DATE], indicated diagnoses of PTSD, cerebral vascular accident (an interruption in the flow of blood to cells of the brain), and dysphagia (difficulty swallowing). Review of Resident R67's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them. During an interview on 7/18/24, at 10:02 a.m. Social Worker Employee E2 confirmed that the facility failed to identify PTSD triggers for Resident R1, and R67 in order to eliminate or mitigate any triggers that may cause re-traumatization for these residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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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. 46336 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications properly and securely in two of three medications carts (East Hall Medication Carts A and B). Findings include: Review of the facility policy Medication Storage in the Facility dated 1/30/24, indicated when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. Observation on 7/15/24, at 11:18 a.m. of the East Hall medication cart B, the following medications failed to have a date opened: Resident R10's albuterol inhaler (breathing medication), opened without a date. Resident R21's ipratropium albuterol (breathing medication), opened without a date. Interview on 7/15/24, at 11:18 a.m. Licensed Practical Nurse (LPN) E18 confirmed the medications failed to have a date opened as required. Observation on 7/15/24, at 11:25 a.m. of the East Hall medication cart A, the following medications failed to have a date opened: Resident R11's Trelegy (breathing medication), and ipratropium albuterol opened without a date. Resident R23's fluticasone (steroid to decreased inflammation), opened without a date. Interview on 7/15/24, at 11:51 a.m. Registered Nurse (RN) Employee E20 confirmed the medications failed to have a date opened as required. Interview on 7/19/24, at 12:30 p.m. the Director of Nursing confirmed that the facility failed to store medications properly and securely in two of three medications carts (East Hall Medication Carts A and B). 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46167 Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to properly store food products, and verify the washing temperature of the dish machine in the Main Kitchen (Main Kitchen), which created the potential for food borne illness. Findings Include: Review of the facility policy Cleaning Dishes/Dish Machine, last reviewed 1/320/24, indicated that the dish machine will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Prior to use, verify proper temperatures and machine function. Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitization. Thermal strips may be used as verification that the temperature is adequately hot. During an observation in the Main Kitchen walk-in refrigerator, on 7/15/23, at 9:45 a.m., a plastic bag containing an employee's lunch dated 7/14/24, was noted to be stored amongst the residents' food supply. During an additional observation on 7/16/24, at 10:40 a.m. in the Main Kitchen walk-in refrigerator the plastic bag containing an employee's lunch dated 7/14/24, was still noted to being stored amongst the residents' food supply. During an interview on 7/16/24, at 10:45 a.m. Dietary Manager Employee E1 confirmed that the facility failed to safely store food products in the Main Kitchen. During an interview on 7/16/24, at 11:00 a.m. Dietary Manager Employee E1 stated that the facility utilized a high temperature dish washing machine. During an interview on 7/16/24, at 12:40 a.m. Dietary Manager Employee E1 informed that Dietary Staff had begun washing the lunch dishes. When Dietary Manager Employee E1 was asked if a test strip had been run through the dishwasher to ensure proper operating temperature, she replied I think they do that after they are done (washing dishes). During an interview on 7/16/24, at 12:40 a.m. Dietary Manager Employee E1 confirmed that running a test strip after the dishes were done, would not be able to identify any issues with the dish machine prior to washing them. Dietary Manager then offered to have a test strip run through the dish machine. During an observation on 7/16/24, at 12:40 a.m. Dietary Manager Employee E1 took a test strip marked Surface and Sink, and ran it through the dish machine. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER William Penn Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 Ader Road Jeannette, PA 15644	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/16/24, at 12:41 a.m. Dietary Manger Employee E1 confirmed that the test strip that was ran through the dish machine was not intended for use in the dish machine, but that it was for the three compartment sink (a sink used to handwash dishes with three different compartments, one used to wash, one to rinse, and one to sanitize dishes) to ensure proper concentration of cleaning chemicals. During an observation on 7/16/24, at 12:41 a.m. Dietary Manager Employee E1 ran another test strip labeled QAC QR (a test strip used to measure the concentration of chemicals when using ammonia) through the dish machine. During an interview n 7/16/24, at 12:42 p.m. Dietary Manager Employee E1 confirmed that the QAC QR strip is not designed to measure temperature in a high temperature dish machine. During an observation on 7/16/24, at 1:42 p.m. the Temperature and Sanitizer Log on the dish machine indicated that log was completed for each meal beginning 7/1/24 at breakfast, through 7/16/24 at lunch (47 entries). All 47 entries stated that the wash temperature was 160 degrees. During an observation on 7/16/24, at 1:42 p.m. the wash cycle temperature gauge was at 145 degrees and did not appear to be moving. During an interview on 7/16/24, at 1:43 p.m. Dietary Manager Employee E1 confirmed that the gauge did not appear to be moving on the dish machine, and that the required temperature reading for a wash cycle on a high temperature dish machine is a minimum of 150 degrees. Dietary Manager Employee E 1 confirmed that the facility failed to verify the washing temperature of the dish machine which created the potential for food borne illness. 28 Pa. Code 201.14(a)Responsibility of licensee. 28 Pa. Code 201.18(b)(1)Management. 28 Pa. Code 211.6c Dietary services.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on facility documents, resident clinical records, and staff interview, it was determined that the facility failed to ensure a representative signed a binding arbitration agreement on behalf of a resident lacking capacity to understand the agreement terms for two of three residents (Resident R2, R60). Findings include: The facility Facility Binding Arbitration Agreements policy last reviewed 1/30/24, indicates the facility asks all residents to enter into a binding arbitration agreement. Review of Resident R60 was admitted [DATE] with diagnoses that include dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), cardiomegaly(enlargement of the heart) and chronic kidney disease. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R60 Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 4/8/22 indicated the resident was assessed as having a BIMS score of 7, which indicates severe cognitive impairment. Review of Resident R60's arbitration agreement dated 4/1/22 indicated a signature from R60. Review of Resident R2 was admitted [DATE] with diagnoses that include chronic kidney disease and hypertensive heart disease (changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation). Review of Resident R2 Admission MDS assessment (Minimum Data Set assessment MDS- a periodic assessment of resident care needs) dated 11/4/23 indicated the resident was assessed as having a BIMS score of 2, which indicates severe cognitive impairment. Review of Resident R2's arbitration agreement dated 11/4/23 indicated a signature from R2. During an interview with Admission Coordinator Employee E25 on 7/18/24 at 11:30 a.m. confirmed Resident R2 & R60 were cognitivly impaired and should not have signed facility paperwork. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code: 201.24(b) Admission Policy 28 Pa Code: 201.14(a) Responsibility of Licensee

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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** 46336 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow enhanced barrier precautions for two of twenty residents (Residents R33 and R74), failed to have proper signage for Transmission Based Precautions, and staff knowledge for one of one positive Covid resident (Resident R180). Findings include: Review of the facility policy Enhanced Barrier Precautions (EBP) dated 1/30/24, indicated EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. A physician order will be obtained for EBP for residents with any of the following wounds, indwelling medical devices even if the resident is not known to be infected with a MDRO. Review of the facility provided Pennsylvania Health Alert Network (PAHAN) 694, dated 5/11/23, indicated establish a process to identify and manage individuals with suspected or confirmed Covid. Ensure everyone is aware of recommended infection prevention practices in the facility. Post visual alerts at the entrance an in strategic places with instructions about current recommendations. Place a patient with suspected or positive COVID infection in a single room. The door should remain closed, and staff should adhere to Standard Precautions and use an approved N95 respirator, gown, gloves, and eye protection. Also known as Transmission Based Precautions. Review of the clinical record indicated Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/9/24, indicated the diagnoses of heart failure (heart doesn't pump blood as well as it should), chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), and malnutrition. Section M0300 indicated a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (dead tissues) may be present on some parts). Observation on 7/19/24, at 10:30 a.m. Resident R33's doorway was adorned with signage for EBP and had PPE (personal protective equipment) outside the door for staff's use. Nurse Aide (NA) Employee E21 was observed providing incontinence care to Resident R33 and failed to have a gown on as required. Interview on 7/19/24, at 10:31 a.m. Registered Nurse (RN) Employee E22 confirmed that NA Employee E21 was providing high contact resident care activity of incontinence care and should have had a gown on as required for EBP. Review of the admission record indicated Resident R74 was admitted to the facility on [DATE]. Review of Resident R74's MDS dated [DATE], indicated diagnoses of a history of falling, displaced Tri malleolar fracture (fracture of the left ankle), high blood pressure, and infection. (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 Resident R74's physician order dated 7/15/24, indicated resident was actively using a wound vacuum to treat his wound and had a PICC line (peripherally inserted venous catheter). The orders failed to include an order for EBP as required. Observation on 7/16/24, at 12:35 p.m. Resident R74's doorway failed to have signage for EBP. NA Employee E23 was observed providing direct high contact care activity and failed to have a gown on. Interview with NA Employee E23 on 7/16/24, at 12:36 p.m. indicated he was unaware he had to wear a gown and confirmed that he did not wear a gown while providing direct high contact care activity. Review of Resident R74's clinical record on 7/16/24, at 12:36 p.m. failed to have a physician order and failed to have a care plan regarding EBP as required. Interview on 7/16/24, at 12:38 p.m. Licensed Practical Nurse (LPN) Employee E24 confirmed Resident R74's record failed to have a physician order and care plan relating to EBP as required. Review of the facility provided Isolation Tracking list dated 7/15/24, indicated Resident R180 has active Covid and was in Covid isolation precautions. Observation of the front lobby entrance on 7/15/24, at 9:00 a.m. failed to have signage notifying staff and visitors that there was an active covid infection in the facility. Review of the clinical record indicated Resident R180 was admitted to the facility on [DATE], with the diagnoses of Covid. Observation of Resident R180's doorway on 7/15/24, at 9:38 a.m. indicated a sign for EBP and not the appropriate signage of Transmission Based Precautions for Covid-19 as required. Interview on 7/15/24, at 9:38 a.m. RN Employee E22 indicated I don't know if Resident R180 is still in isolation for Covid or not. I think everyone tested negative over the weekend. I'm not sure what the policy is for that. You'll have to ask the Director of Nursing. Interview with the Director of Nursing on 7/15/24, at 9:40 a.m. indicated Resident R180 was on day five of ten for transmission-based precautions and confirmed the facility failed to place appropriate signage on Resident R180's door and the front lobby entrance, and that the RN Employee E22 should have known Resident R180 remained in transmission-based precautions for positive covid infection. Interview on 7/19/24, at 12:30 p.m. the Director of Nursing confirmed the facility failed to follow enhanced barrier precautions for two of twenty residents (Residents R33 and R74), failed to have proper signage for Transmission Based Precautions, and staff knowledge for one of one positive Covid-19 resident (Resident R180). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46336 Based on review of facility records and staff interviews, it was determined that the facility failed to have a designated Infection Preventionist (IP) qualified with specialized training in infection prevention and control for six of twelve months (February 2024 - July 2024). Findings include: Upon review of the infection prevention tasks during annual survey 7/15/24, it was discovered that the Director of Nursing was also the current Infection Preventionist. Interview on 7/15/24, at 9:18 a.m. the Nursing Home Administrator confirmed that the Director of Nursing has been covering the Infection Preventionist (IP) role since the previous IP's last day of work on 2/5/24. Interview on 7/19/24, at 12:30 p.m. the Nursing Home Administrator confirmed that the facility failed to have a designated Infection Preventionist (IP) qualified with specialized training in infection prevention and control for six of twelve months (February 2024 - July 2024). 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46336 Based on review of facility in-service documentation, personnel records, and staff interviews it was determined that the facility failed to implement and maintain an effective training program for five of ten employee files reviewed (Nurse Aides (NA) Employee E9, NA Employee E16, NA Employee E25, NA Employee E27, and Licensed Practical Nurse (LPN) Employee E26). Findings include: Review of NA Employee E9's personnel record indicated a date of hire on 7/5/2010. Review of NA Employee E9's personnel record did not include annual in-service training on resident rights, abuse, quality assurance performance improvement (QAPI), and behavioral health training in the last year. Review of NA Employee E16's personnel record indicated a date of hire on 7/10/2014. Review of NA Employee E16's personnel record did not include annual in-service training on abuse, dementia care, infection control, communication, QAPI, falls/incident accident, restorative care, emergency preparedness, and fire safety in the last year. Review of NA Employee E25's personnel record indicated a date of hire on 7/5/12. Review of NA Employee E25's personnel record did not include annual in-service training on QAPI, falls/incident accident, resident rights, communication, behaviors, and fire safety in the last year. Review of NA Employee E27's personnel record indicated a date of hire on 4/13/23. Review of NA Employee E27's personnel record did not include annual in-service training on communication, restorative care, emergency preparedness, and fire safety in the last year. Review of LPN Employee E26's personnel record indicated a date of hire on 9/29/16. Review of LPN Employee E26's personnel record did not include annual in-service training on communication, resident rights, QAPI, infection control, behavioral health, restorative care, emergency preparedness, and fire safety in the last year. Interview on 7/17/24, at 2:15 p.m. Human Resource Employee E10 confirmed that the facility failed to implement and maintain an effective training program for five personnel record as required. 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code: 201.14(a) Responsibility of licensee.