STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396078	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46106 Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility-initiated emergency transfers to the hospital and that a resident's representative was made aware of a facility-initiated transfer, for two of eight residents reviewed. (Residents R67 and R237) Findings Include: Review of nursing notes for Resident R67 dated November 10, 2024, at 10:18 a.m. revealed that the resident had a unwitnessed fall and was transferred to a local hospital for evaluation. Further review revealed a note, dated October 8, 2024, at 11:16 p.m., which indicated that Resident R67 was admitted to the local hospital for feeling nauseous and dizzy and was observation with syncope. Further record review for another Residents R237 revealed that November 24, 2024, at 3:14 p.m. revealed that resident pulled the hypodermoclysis out and family wanted to send resident to hospital to be evaluated. Further review revealed a note, dated June 11, 2024, at 10:19 a.m. revealed that Resident R237 pulled out Peg tube and was send to hospital. Further review revealed a note, dated March 18, 2024, at 2:13 p.m. revealed that resident's peg tube on his bed came out from abdomen and was send to hospital. Review of documentation provided by the Assistant Administrator, Employee E15, on February 6, 2025, at 1:38 p.m., revealed the Office of the State Long Term Care Ombudsman was not made aware Residents R67 and R237's facility-initiated emergency transfers to the hospital as required. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management

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

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

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F 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** 46106 Based on clinical record review and interview with staff, it was determined that the facility did not ensure that care plans were updated in a timely manner for one of 35 records reviewed related to resident's behaviors of dislodging a peg tube (Resident R237). Findings include: Review of facility undated policy, titled Care Plans, Comprehensive Person- Centered dated in March 2022 indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessment of resident's are ongoing, and care plans are revised as information about the residents and the residents' conditions changes. Review of clinical documentation revealed that Resident R237 was admitted to the facility on [DATE], and had diagnoses of benign neoplasm of stomach, Alzheimer's disease (progressive degenerative disease of the brain), Gastrostomy status, unspecified protein-calorie malnutrition, and attention- deficit hyperactivity. Further review revealed a note, dated March 18, 2024, at 2:13 p.m. revealed that resident's peg tube on his bed came out from abdomen. Further review revealed a note, dated June 11, 2024, at 10:19 a.m. revealed that resident pulled out peg tube. Reviewed of nursing notes for Resident R237 revealed that on December 12, 2024, at 10:59 a.m. nursing aide notified nurse of peg tube being out of the resident's stomach. Resident R237 stated that he pulled the peg tube out. Review of Resident's R237's care plan revealed that there was no care plan developed related to the resident's were behavior of pulling of his peg tube. Interview with Director of Nursing Employee E2, on February 7, 2025, at 2:15 p.m. was confirmed that resident's care plan needed to be revised related to the resident pulling the peg tube out. 28 Pa. Code 211.10 (d) Resident care policies 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. 46993 Based on interview with residents, interview with staff, and review of clinical records, it was determined that facility failed to obtained a consultation with an especialist and administered insulin medications as ordered by the physican for two of 35 residents reviewed. (Resident R40 and Resident R94) Findings include: Review of Resident R40's clinical record, revealed medical history of multiple sclerosis (slow progressive disease of the cenetal nervous system), paraplegia (paralysis on the lower half of the body), lymphedema (condition of localized swelling caused by a compromised lymphatic system) and muscle weakness. Interview with Resident R40 on Tuesday, on February 4, 2025, at 11:00 a.m., revealed that she has not seen a lymphedema specialist after communicating her preference with nursing staff over past seven months. Review of Resident R40's clinical record revealed an active physician order, obtained on August 31, 2024, for lymphedema therapy consult. Further review of Resident R40's clinical record revealed physician note, dated January 23, 2025, at 3:15 p. m., indicating to monitor for chronic bilateral lower extremity edema. R40 has been refusing diuretic and ace wrapping. she continues to state no one is doing anything about her condition . consider lymphedema therapy/vascular consult order previously appears still pending. Review of facility provided statement from unit clerk, Employee E9, dated February 7, 2025, revealed the following: Last summer it was requested that I look into lymphedema treatment centers in the area. I discussed with a colleague who stated that the only one they know of was closed. I also texted my old clinical manager at (cancer center) to see if she knew of anywhere, and unfortunately she did not. When I researched online, I was unable to locate any place that would be helpful. Review of Resident R40's clinical record revealed no documented evidence of a follow-up with Resident R40 regarding a lymphedema consult appointment. Review of facility policy 'Insulin Administration,' revised September 2014, indicates that the type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. Review of Resident R94's clinical record, on February 5, 2025, revealed medical history of chronic kidney disease - stage 3, type 2 diabetes mellitus with diabetic neuropathy. Review of Resident R94's physician orders revealed Novolog pen fill subcutaneous solution cartridge 100 unit/ml (insulin Aspart) inject 8 unit subcutaneously before meals for diabetes, to be administered at 11:00 a. m. (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 facility provided audit medication administration report revealed that on February 2, 2025, insulin Aspart was administered at 2:04 pm, by licensed nurse, employee E10. 28 Pa Code 211.12(d)(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. 38735 Based on observation, record review, and staff interviews, it was determined the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for three of 35 residents reviewed (Residents R406, R18, and R114). Findings include: Review of Resident 406's clinical record revealed diagnoses including Chronic Respiratory Failure with hypoxia (the lungs cannot adequately oxygenate the blood, leading to low oxygen levels). Review of Resident 406's clinial record failed to reveal a physician's order for oxygen therapy. Observations conducted of Resident R406's room on February 4, 2025, at 10:30 a.m. revealed Resident 406 was wearing his/her oxygen and the filter on the concentrator contained an abundance of grey, fuzz substance. Review of Resident R18's clinical record revealed diagnoses including Chronic Respiratory Failure with hypoxia (the lungs cannot adequately oxygenate the blood, leading to low oxygen levels). Further review of Resident R18's clinical record revealed a September 29, 2024, physician's order for oxygen at 2 litters per minute continuously. Observations conducted of Resident R18's room on February 4, 2025, at 10:45 a.m. revealed Resident R18 was wearing his/her oxygen and the filter on the concentrator contained a buildup of whiteish, grey, fuzz substance. Review of Resident R114's clinical record revealed diagnoses including Chronic Respiratory Failure with hypoxia (the lungs cannot adequately oxygenate the blood, leading to low oxygen levels). Observations conducted of Resident R114's room on February 4, 2025, at 10:55 a.m. revealed Resident R18 was wearing his/her oxygen and the filter on the concentrator contained a buildup of grey, fuzzy substance. During an interview with the Unit Manager, Employee E8 on February 4, 2025, at 11:45 a.m., it was revealed that the oxygen concentrator filter in these three rooms needed to be cleaned. 28 Pa code 211.12(d)(1)(2)-Nursing Services

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F 0698 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of clinical records, interviews with staff, and facility policy, it was determined the facility failed to ensure residents who require dialysis treatment receive such services, consistent with professional standards of practice, including ongoing assessment of the resident's condition and monitoring for complications before, during, and after dialysis treatments for one of three dialysis resident's reviewed (Resident R104). The facility's failure to properly monitor Resident R104's right arm fistula (used for dialysis access) resulted in actual harm to Resident R104 who required an emergent transfer to the hospital from the dialysis center when the resident's fistula was assessed as swollen, infected with purulent (thick, yellowish substance that occurs with infection) drainage and the development of a non-occlusive right brachial deep vein thrombosis. (Resident R104). Findings include: Review of the facility's policy titled, Hemodialysis Catheters-Access and Care of revised on, February 2023, indicates, after placement of the fistula or graft, the site cannot be accessed until it matures which may take 2-3 weeks for a graft and 6-12 weeks for a fistula. The primary goal is to prevent infection and maintain patency of the catheter (preventing clots). To prevent infection and/or clotting the site needs to be clean at all times. Check for signs and symptoms infection (warmth, redness, tenderness, or edema) at the access site when performing routine care. Check the color of the fingers and the radial pulse of the access arm when performing routine care and at regular intervals. Check the patency of the site at regular intervals, palpate the site to feel the Thrill or use a stethoscope to hear the whoosh sound or bruit. The nurse should document in the resident's medical record every shift the location of the catheter, condition of dressing (interventions if needed), if dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given, and observations post-dialysis. Review of Resident R104's clinical record revealed, Resident R104 was admitted to the facility on [DATE], diagnosed with end state renal disease and ordered to receive hemodialysis (acts like an artificial kidney, removes waste and fluid from the body) three times a week on Tuesday, Thursday and Fridays. On November 13, 2024, Resident R104's nursing progress note revealed the resident returned from the hospital status post-surgery for the resident's right arm fistula (used for dialysis access) was noted wrapped with an ACE bandage from fingertips to the resident's upper arm, with no signs of swelling. Review of Resident R104's November 2024 physician's orders revealed there were no evidence the attending physician's orders were obtained for the care and monitoring of the resident's right arm fistula when returning from the hospital. Review of Resident R104's nursing skin checks documentation dated November 15, 2024, revealed no signs and symptoms of infection. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	Review of physician orders revealed an order obtained on November 25, 2024, for the antibiotic, Doxycycline Hyclate 100 milligrams tablet, to be given twice a day for 10 days due to erythema (redness) at the surgical sight. On November 26, 2024 nursing note for Resident R104 indicated the antibiotic was used for the resident's erythema at surgical site and that the right arm remained swollen and the resident returned from dialysis without issues. On November 27, 2024, nursing note notes indicated [Resident R104]'s use of antibiotic for erythema to surgical scar with no swelling or tenderness with arm wrapped with ace bandage. November 27, 2024, nursing note indicates, Resident R104 use of antibiotic for erythema to surgical scar with no swelling or tenderness with arm wrapped with ace bandage. Continuing the review of Resident R104's nursing notes dated, November 28, November 29, November 30, December 1, 2, 3, 4, and December 5, 2024 revealed the resident continued on the antibiotic, erythema was still observed at the surgical site, right arm remained swollen with the ace wrap in place. Continued review of Resident R104's nursing documentation revealed there was no evidence the resident's physician was notified by nursing staff that the resident right arm continued to be swollen when the antibiotics were completed on December 5, 2024. Further review of nursing notes from December 6, 2024 through December 9, 2024 did not reveal the resident's right surgical wound was assessed/evaluated. Review of facility documentation title Long term care evaluation dated December 16, 2024, noted non pitting edema, not dependent upon positioning, documented as 'not new,' was located on Resident R104's right palm of hand, right upper arm, right anterior elbow, and right forearm. Review of Resident R104's nursing skin check dated December 17, 2024, failed to document the status of Resident R104's swollen arm but stated at the time of assessment the resident was off the unit and the wound was wrapped. On December 19, 2024, Resident R104's nursing progress note indicated the resident was Sent out to the hospital ER (emergency room) for evaluation on swollen right arm. Dialysis team called this nurse and stated that they reached out to nephrology in regard to resident swollen right arm and resident needs ER visit ASAP (as soon as possible). Review of hospital records revealed Resident R104 presented to the emergency on December 19, 2024, with right upper extremity erythema edema, cellulitis/abscess with purulent drainage (thick milky foul smelling drainage commonly called pus) from his fistula site, also with nonocclusive right brachial DVT (Deep Venous Thrombosis-blood clot) and was placed on Vancomycin (an antibiotic used for severe infections). (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	The correspondence/communication between the facility and dialysis center during that time period was either incomplete or not found. Resident R104 was also found to have two dialysis communication books both with missing and/or incomplete data between both parties. Due to a lack of documentation, the Unit Manager Employee E19 on February 7, 2025, at 10:30 a.m. was asked about the progression of Resident R104's surgical wound and the infection. The Unit Manager could not provide any additional information other than stating, We were wrapping his arm and when his arm swelled, he was sent to the hospital. Interview with the Director of Nursing on February 7, 2025 at 5:00 p.m. confirmed there were no orders obtained related to the care of the right arm fistula upon the resident's returned from the hospital on November 13, 2024. The facility failed to properly monitor and assess Resident R104's right arm fistula (used for dialysis access) for complications during and after dialysis treatments which resulted in actual harm to Resident R104 who required an emergent transfer to the hospital from the dialysis center when the resident's fistula was assessed as swollen, infected with purulent drainage and the development of a non-occlusive right brachial deep vein thrombosis. 28 Pa. Code: 211.10(c) Resident care policies 28 Pa Code 211.5(f)(ix) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46106 Based on observations, interview with residents and staff, it was determined that the facility did not provide sufficient nursing staff at all times to provide nursing and related services to meet the resident's needs for 12 out of 35 residents reviewed (Resident R180, R46, R155, R247, R75, R78, R137, R32, R134, R11, R161 and R7) Findings include: Review of facility's policy 'Call System, Residents,' revised September 2022, indicates that calls for assistance are answered in a timely fashion. Observations on Tuesday, February 4, 2025, on D3 unit, revealed call bell light on appeared at 9:45 a.m., room#304. Continued observation on D3 unit, revealed call bell light still on at 10:16 am, room#304. Interview with Resident R180, in room [ROOM NUMBER], on February 4, 2025, at 10:30 am, revealed that late call bell response time is common and he believes nurse aides quit or left to another unit. Interview with Resident R217, on February 4, 2025, unit D3, at 11:15 a.m. Interview with Resident R15, unit D2, on February 4, 2025, unit D3, at 11:30 a.m., revealed concern with facility not having enough nurse aides. Interview with Resident R111, on February 4, 2025, at 11:35, unit D2, revealed concern with facility not having enough nurse aides. Interview with Resident R16, unit D2, on February 4, 2025, at 11:40 a.m., revealed concern with facility not having enough nurse aides which affects her shower days. Interview with Resident R73, unit D2, on February 4, 2025, at 11:45 a.m., revealed concern with facility not having enough nurse aides which affects her shower days. Interview with nursing aide, Employee E16, on February 4, 2025, at 11:12 a.m., revealed that she has 13 residents on her case loaded and only 2 nursing aides working during the day shift. Also feels overwhelmed with the resident's case loaded and asked the facility to have more staff on each unit but nothing was provided. Interview with Resident R46 on February 5, 2025, at 1:16 p.m. revealed concern with call bell not been answered in timely manner and medication not been giving in timely manner because of not enough staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident council meeting was held on February 5, 2025, at 10:30 a.m. with alert residents R247, R75, R78, R137, R32, R134, R11, R161 and R7, reported the biggest concern in this facility is not having enough of nursing aides and nurses on each unit. Call bells are not answered in a timely manner, residents must wait 45 mins to one hour to get help. A lot of falls happened because residents get up to use the bathroom without assistant due to not having enough staff and staff support. Medication is not pass out in the timely manner because not enough nurses on each unit. 28 Pa Code 211.12(d)(4) Nursing services 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(a)(3) management

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46993 Based on review of facility provided documentation, it was determined that facility did not ensure nurse aides had completed annual performance evaluation for three out of nine nurse aides reviewed (Employee E11, E12, E13) Findings include: Review of facility policy 'Performance Evaluations,' revised September 2020, indicates that a performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. Request to review nurse aide performance evaluations on Wednesday, February 5, 2025, at 12:05 p.m. revealed facility was unable to provide completed performance evaluation for nurse aide, Employees E11 and E12. Request to review additional nurse aide performance evaluations on Friday, February 7, 2025, at 11:15 a.m., revealed facility was unable to provide completed performance evaluation for nurse aide, Employee E13. 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46106 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address a resident's dementia care needs for one of 35 residents reviewed (Resident R46). Findings Include: Reviewed facility dementia policy title Dementia Clinical Protocol dated in November 2018 states that treatment/management for the individual with confirmed dementia, the IDT team will identify a resident-centered care plan to maximized remain function and quality of life. Review of the admission sheet of Resident R46, revealed that Resident R46 was admitted to the facility on [DATE], with the diagnosis of Dementia (Dementia is not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Review of Minimun Data Set (MDS- assessment of resident care needs) revealed that Resident R46 received antipsychotic (Antipsychotic medications have the effect of changing a person's behavior, mood, and emotions). On February 7, 2025, at 10:04 a.m., review of Resident 46's care plan revealed no care plan with measurable goals and interventions to address the care and treatment need related with dementia care of Resident R46. During an interview on February 7, 2025, at 9:44 a.m., the Director of Nursing (DON), confirmed that residents with diagnosis Dementia should be care planned. 28 Pa Code 211.11(d) Resident care plan 28 Pa Code 211.12 (d)(1)(3)(5) Nursing service

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38735 Based on observations, resident and staff interviews, it was determined that the facility failed to provide food and drink that was palatable and served at palatable temperatures for 15 of 35 residents reviewed (Residents R114, R55, R406, R10, R268, R204, R31, R18, R285, R407, R22, R221, R182, R28 and R118). Findings include: Interview with Resident R114 on February 4, 2025, at 9:55 a.m. revealed that the food is always served cold. Interview with Resident R55 on February 4, 2025, at 9:59 a.m. revealed that he does not care for the food, it is just not good, they could do a lot better. Interview with Resident R406 February 4, 2025, at 10:03 a.m. revealed that the food does not taste good, and it is not always hot enough. Interview with Resident R268 February 4, 2025, at 10:06 a.m. revealed the food is cold, especially the scrambled eggs. He stated that the kitchen staff say it is hot when it leaves the kitchen but it takes too long to be delivered. He said that he doesn't like that the meat is served only at night and at lunch it is too much starch and cheese, not good for a diabetic worried about cholesterol. He said that most days he can only eat the soup. Interview with Resident R10 on February 4, 2025, at 10:10 a.m. revealed that she does not like the food, and it is often cold when she gets it. Interview with Resident R204 on February 4, 2025, at 10:13 a.m. revealed that the food is not always hot, and you don't always get what is on the meal ticket. Interview with Resident R31 on February 4, 2025, at 10:17 a.m. revealed that she thinks that the food is horrible, she just doesn't like it at all, and that it is often too cold. Interview with Resident R18 on February 4, 2025, at 10:20 a.m. revealed that the food is horrible, she can't eat anything with their mayonnaise and that cuts out the chicken and egg salad sandwiches which I love, and so that kills me. Interview with Resident R285 on February 4, 2025, at 10:23 a.m. revealed that the food is often served cold. Interview with Resident R407 on February 4, 2025, at 10:27 a.m. revealed that the food is not very good and it could be hotter. Interview with Resident R22 on February 4, 2025, at 10:31 a.m. revealed that she does not like the food, it is really bad. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396078	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident R221 on February 4, 2025, at 10:35 a.m. revealed that he doesn't like the food, it is poor quality, and he doesn't think they follow the Kosher laws, that the Rabbi is not inspecting the food like they should. He said that he does not eat it that often. Interview with Resident R182 on February 4, 2025, at 10:44 a.m. revealed that he doesn't eat the food, it is sometimes cold, and that he usually orders out. Interview with Resident R118's spouce on February 4, 2025, at 11:41 a.m. revealed that the food does not taste good, and is often burned or cold, and that the meat is of low quality. Observations during a test tray conducted with the Dietitian, Employee E6, on February 5, 2025, at 12:20 p. m. revealed that the Brussels sprouts were 124.5 degrees and below 135 degrees, and the skim milk was 50 degrees, and the red gelatin was 53.4 degrees. The macaroni and cheese tasted bland with little cheese flavor, the skim milk tasted warm, and the gelatin was not cool or firm. An interview with the the Dietitian, Employee E6, on February 5, 2025, at 12:30 p.m. confirmed that these food items were outside the acceptable temperature range and therefore not palatable. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based upon review of resident records and interviews with staff it was determined that the facility failed to maintain ongoing communication between the facility and a dialysis provider that was completed and/or available for review for three of three residents receiving dialysis (Resident R104, R139 and R230). Findings include Resident R104 was admitted to the facility on [DATE], diagnosed with end state renal disease and was ordered to receive hemodialysis three times a week on Tuesday, Thursday and Fridays. Hospital records revealed Resident R104 presented to the emergency on December 19, 2024, with right upper extremity erythema edema, cellulitis/abscess with purulent drainage (thick milky foul smelling drainage commonly called pus) from his fistula site, also with nonocclusive right brachial DVT (blood clot) and was placed on Vancomycin (an antibiotic used for severe infections). The correspondence/communication between the facility and dialysis center during that time period was either incomplete or not found. Resident R104 was also found to have two dialysis communication books both with missing and/or incomplete data between both parties. Due to a lack of documentation, the Unit Manager on February 7, 2025, at 10:30 a.m. was asked about the progression of Resident R104's surgical wound and the infection. The Unit Manager could not provide any additional information other than stating, We were wrapping his arm and when his arm swelled, he was sent to the hospital. Review of Resident R139's clinical record revealed a physician's order for hemodialysis every Monday, Wednesday and Friday with a 3:00 p.m. chair time at an on-site dialysis center. Further review of Resident R139's dialysis log record revealed that only eleven of nineteen log pages were completed with one page (2/5/25) having no documentation from the dialysis center on the resident's clinical information, and the other ten pages (12/24/24, 12/27/24, 12/29/24, 1/3/25, 1/10/25, 1/17/25, 1/20/25, 1/24/25, 1/29/25 and 1/31/25) missing the post-dialysis documentation from the facility evening staff. Interview with the Unit Manager, Employee E8, on February 7, 2025, at 9:30 a.m. confirmed that the dialysis center had failed to complete the clinical documentation on February 5, 2025, and that the facility nurse should have completed the post-dialysis documentation on the other ten dates for Resident R139. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.5(g) Clinical records

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46993 Based on review of facility provided documentation and interview with staff, it was determined that facility did not ensure required in-services training was provided for one nurse aide out of nine nurse aides reviewed (Employee E14) Findings include: Review of facility policy 'In-Service Training, Nurse Aide,' revised August 2022, indicates that in-service training is based on the outcome of the annual performance review, annual in-services: are no less than 12 hours per employment year. Request to review regular in-service education for nurse aides, on Wednesday, February 5, 2025, at 12:05 pm, revealed facility unable to provide completed in-service education for nurse aide, Employee E14. 28 Pa Code 201.19(7) Personnel policies and procedures 28 Pa Code 201.20(d) Staff development