STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396149	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Care Center of Butler	115 Technology Drive Butler, PA 16001

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of clinical records and staff interview, it was determined that the facility failed to notify the family of a change in condition in a timely manner for one of three residents (Resident R11). Findings include: Review of the clinical record indicated that Resident R11 was admitted to the facility on [DATE], with diagnoses which included adult failure to thrive (a syndrome of global decline that occurs in older adults as a worsening of physical frailty that is also compounded by cognitive impairment), atrial fibrillation (irregular heart rhythm), and benign prostatic hyperplasia (BPH age associated prostate gland enlargement). Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/8/24, indicated the diagnoses remain current. Review of Resident R11's current care plan on 4/30/24, indicated resident will tolerate tube feedings with no signs of complications including aspiration, weight loss, dehydration, excoriation (redness) at insertion site, etc. Review of a progress note dated 4/18/24, at 7:15 p.m. indicated that Resident R11 was transferred to the hospital at 5:30 p.m. by previous shift. Resident R11's son came in to visit and stated he was not notified of father being transferred to the hospital. Registered Nurse (RN) Employee E1 notified him he was transferred due to G tube (tube inserted into the stomach via surgical intervention) needing evaluated. Documentation did not include notification of the family by the previous shift. During an interview on 5/2/24, at 11:00 a.m. the Director of Nursing confirmed that the facility failed to notify the family of a change in condition in a timely manner for one of three residents (Resident R11). 28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on the Code of Federal Regulations (CFR), clinical records, facility documents, and staff interviews, it was determined that the facility failed to provide timely notice of the Notice of Medicare Non-Coverage (NOMNC) for one of three sampled resident records (Closed Resident Record CR1). Findings include: Review of the CFR indicated at GUIDANCE S483.10(g)(17)-(18), the NOMNC, Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization. Review of Closed Resident Record CR1's admission record indicated she was admitted on [DATE], with diagnoses that included breast cancer, kidney failure (condition where the kidneys lose the ability to remove waste and balance fluids), and falls. Review of Closed Resident Record CR1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/19/24, indicated the diagnoses were the most recent upon review. Review of Closed Resident Record CR1's NOMNC indicated the effective date coverage of skilled services will end as 3/27/24. Review of the same NOMNC indicated the resident was provided and signed the form on the same day of 3/27/24. During an interview on 5/1/24, at 10:58 a.m. the Nursing Home Administrator confirmed that the facility failed to provide timely notice of the Notice of Medicare Non-Coverage (NOMNC) for one of three sampled resident records (Closed Resident Record CR1). 28 Pa. Code 201.29(a): Resident rights. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 46337 Based on facility policy, observation, and staff interview, it was determine the facility failed to provide privacy and confidentiality of resident healthcare information on one of eight residents (Resident R128). Findings include: During an observation in Resident R128's room on 4/30/24, at 10:45 a.m. a Congestive Heart Failure (CHF-is a condition where your heart can't pump blood well enough to meet your body's need) Blood Pressure Log was posted on the resident's bathroom door. The resident's name, blood pressure, pulse, weight, and symptoms from 4/24/24, to 4/30/24 were observed. During an interview on 4/30/23, at 10:49 a.m. Registered Nurse, Employee E7 confirmed the facility failed to provide privacy and confidentially of resident health information for one of eight residents (Resident R128). 28 Pa. Code: 211.5(b) Clinical records. 28 Pa. Code: 201.29(j) Resident rights.

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F 0600 Level of Harm - Minimal harm or potential for 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** 46336 Based on review of facility policies, documents and clinical records and staff interviews, it was determined that the facility failed to make certain a resident was free from abuse and neglect for one of five residents reviewed (Resident R5). Findings include: The facility's policy Abuse Neglect, and Exploitation Policy dated 2024, indicated it is the facility's policy to provide a safe and secure environment for all residents and will protect a resident's right to be free from any form of abuse, mental abuse, neglect; reports of theft, exploitation, or misappropriation of resident property. o 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 2/1/24, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe). Section GG indicated partial-moderate assistance was required for personal hygiene. Review of a facility submitted report dated 3/9/24, indicated Licensed Practical Nurse (LPN) Employee E2 reported to the Director of Nursing that while assisting Resident R5 with morning care she observed two briefs on the resident. Review of Employee Witness Statement dated 3/9/24, indicated LPN Employee E2 was helping resident in bathroom and discovered the resident had two pull up briefs (incontinence adult diapers). When LPN Employee E2 questioned Resident R5 about who had helped her get dressed, Resident R5 was able to identify Nurse Aide Employee E3. Review of Employee Witness Statement dated 3/9/24, indicated the Director of Nursing (DON)telephoned Nurse Aide Employee E3, who did not admit to placing two briefs on Resident R5. NA Employee E4 assigned to the area indicated to the DON that she did not get Resident R5 out of bed today and that she was aware that staff were not permitted to double brief the residents; however, NA Employee E3 the overnight NA had gotten resident ready. Interview with Resident R5 and the DON indicated that Resident R5 was able to identify the NA who got her dressed that day as NA Employee E3. Review of facility investigation dated 3/9/24, at 4:41 p.m. indicated the facility's conclusion that Nurse Aide Employee E3 was found to be negligent in care practices and was removed from the facility schedules. Interview with the DON on 5/2/24, at 9:32 a.m. indicated when the Interim DON was there they talked to NA Employee E3 and told her that double briefing is not a policy of the facility and rounding every two hours is the policy. This was the second time it happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/5/23, at 1:00 p.m. the Director of Nursing confirmed that the facility failed to make certain a resident was free from abuse and neglect for one of five residents reviewed (Resident R5). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 201.18(b)(e)(1)(2) Management 28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on clinical record review and interview with facility staff, it was determined that the facility failed to provide a written notice of bed hold policy for residents at the time of transfer to an acute care facility for two of three residents reviewed (Resident R6 and R14). Findings include: Review of the Code of Federal Regulations (CFR) S483.15(d) Notice of bed-hold policy and return. S483. 15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE], with diagnoses that included diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), high blood pressure, and coronary artery disease (narrow arteries decreasing blood flow to heart) . Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/27/24, indicated the diagnoses remained current. Review of a progress note dated 4/28/24, at 2:30 a.m. indicated a new order was received for Resident R6 to be sent to the hospital for respiratory distress. The clinical record did not include a written Bed Hold Policy Notice & Authorization form as required. Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE], with diagnoses that included dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), high blood pressure, and seizure disorder (a person experiences abnormal behaviors, symptoms, and sensations, sometimes including loss of consciousness). Review of a progress note dated 3/19/24, at 7:23 p.m. indicated a new order was received for Resident R14 to be sent to the emergency room due to a painful and abnormal appearance of the left hip. The clinical record did not include a written Bed Hold Policy Notice & Authorization form as required. Interview on 5/2/24, at 10:46 a.m. Social Worker Employee E8 indicated we review it upon admission and call the family when they go to the hospital to see if they want to hold the bed. We do not send a written notice at the time of transfer. Interview on 5/22/24, at 2:30 p.m. the Nursing Home Administrator confirmed the facility failed to provide a written notice of bed hold policy for residents at the time of transfer to an acute care facility for two of three residents reviewed (Resident R6 and R14). (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 PA Code: 201.29(j) Resident rights. 28 Pa. Code 201.20(a)(b)(c)(d) Staff Development. 28 Pa Code: 201.14 (a) Responsibility of licensee 28 Pa Code: 201.18 (b)(1) Management.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of clinical record, facility policy, and staff interview, it was determined that the facility failed to develop a baseline care plan that included interventions needed to provide effective and person-centered care for one of eight residents (Resident R130). Findings include: The facility policy Interdisciplinary Resident Care Planning Policy dated 1/7/22, last reviewed 2024, indicated a baseline care plan to meet the resident's immediate needs shall be developed within forty-eight hours of the resident's admission. Review of the admission record indicated Resident R130 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and high blood pressure. Review of Resident R130's physician order dated 4/5/24, indicated the resident receives Dialysis Monday, Wednesday, and Friday. Review of Resident R130's clinical record from 4/5/24, through 4/7/24, failed to include a baseline care plan that was implemented to address the resident's dialysis. The facility failed to provide effective and person-centered care. During an interview on 5/1/24, at 11:59 a.m. the Case Coordinator, Employee E6 confirmed that the facility failed to implement a baseline care plan to provide effective and person-centered care for one of eight residents (Resident R130). 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, resident observations, clinical record review and staff interviews, it was determined that the facility failed to implement a resident's plan of care for two of 17 residents. (Resident R11 and R130). Findings include: Review of the facility Interdisciplinary Resident Care Planning policy dated 12/1/20, last reviewed 2024, indicated the interdisciplinary team will assess the resident to identify needs, problems, and strengths to develop a plan of care, including appropriate goals. The care plan will be a working document reflecting the current status of the resident and will be utilized for all aspects of care, including documentation. Review of the clinical record indicated that Resident R11 was admitted to the facility on [DATE], with diagnoses which included adult failure to thrive (a syndrome of global decline that occurs in older adults as a worsening of physical frailty that is also compounded by cognitive impairment), atrial fibrillation (irregular heart rhythm), and benign prostatic hyperplasia (BPH age associated prostate gland enlargement). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of Section M1040 indicated resident had a skin tear, and received nonsurgical dressings and medications. Review of Resident R11's wound documentation form on 4/1/24, indicated a large open wound to right lower extremity. Review of Resident R11's physician orders dated 4/22/24, indicated a treatment of Santyl, calcium alginate and a dry dressing (a collagen based wound treatment) to right lower extremity wounds. Review of Resident R11's care plan on 5/2/24, at 9:00 a.m. failed to include a plan of care for the large open wound to right lower extremity. Interview on 5/2/24, at 9:42 a.m. Case Coordinator, Employee E6 confirmed there was not a plan of care for the large open wound to right lower extremity. Review of the admission record indicated Resident R130 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and high blood pressure. Resident R130's Minimum Data Set (MDS-periodic assessment of care needs) dated 4/24/24, indicated the diagnosis were current. Section M: Skin Conditions indicated the resident had four Stage 2 pressure injuries (partial thickness loss of top layer of skin presenting as a shallow open ulcer, or may present as an intact or open/ruptured blister.) It was indicated one of the four pressure injuries were present upon admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R130's care plan dated 4/7/24, indicated to complete the Braden Scale weekly times 4 on an admission/readmission, quarterly, and with a significant change. Review of Resident R130's clinical record from 4/15/24, through 4/29/24, failed to reveal a weekly Braden Scale assessment was completed as the care plan indicated. During an interview on 5/1/24, at 12:17 p.m., Case Coordinator, Employee E6 confirmed the facility did not complete a weekly Braden Scale assessment from 4/15/24, through 4/29/24, and the facility failed to implement a plan of care for Resident R130. Interview on 5/2/24, at 2:00 p.m. the Director of Nursing confirmed the that the facility failed to implement a resident's plan of care for two of 17 residents. (Resident R11 and R130). 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: S211.10(c) Resident care policies.

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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** 46337 Based on review of clinical records and staff interviews, it was determined that the facility failed to implement a bowel protocol as ordered for one out of four residents. (Residents R126). Findings Include: Review of the facility Bowel Management policy dated 12/1/20, last reviewed 2024, indicated it is the facility's policy to assure each resident is assessed and managed for adequate bowel elimination. Nursing staff will establish a bowel movement schedule based on individual patterns. Review of the clinical record revealed that Resident R126 was admitted to the facility on [DATE]. Review of Resident R126's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/26/24, indicated diagnoses of high blood pressure, and encounter for surgical aftercare following surgery of the digestive system. Review of Resident R126's physician order dated 4/19/24, indicated to administer 30 ml of Milk of Magnesia (also known as MOM, laxative that is thought to work by drawing water to the intestines, to assist with a bowel movement) 400 MG/5ML by mouth as needed, every second day for constipation. Review of Resident R126's physician order dated 4/19/24, indicated to insert one Bisacodyl suppository 10mg rectally as needed, every three days for constipation. Review of Resident R126's BM report dated 4/19/24, through 5/1/24, failed to indicate that Resident R126 had a bowel movement from 4/21/24, though 4/25/24. A total of four days. Review of Resident R126's clinical record from 4/21/24, through 4/25/24, failed to indicate the resident was administered MOM or Bisacodyl as ordered and the bowel regimen for no bowel movement. During an interview on 5/2/24, at 12:22 p.m. Nurse Aide (NA), Employee E11 stated resident's bowel movements are documented in the clinical record and is communicated with the next shift and nurses. It was indicated if a resident failed to have a bowel movement in three days, staff must relay it to next shift and notify nurse. During an interview on 5/2/24. at 12:24 p.m. Licensed Practical Nurse (LPN), Employee E12 stated: We will check with aides to see if residents had a bowel movement, and aides will let us know throughout shift. It was indicated at the end of shift, if a resident doesn't have a bowel movement, then the oncoming shift is notified. On day 2 MOM, which is an in-house standard order will be administered, then if ineffective, a suppository day 3, and lastly if that is ineffective then an enema is administered. It was indicated medications are signed off in the resident's clinical record, then marked if effective or non-effective. During an interview on 5/2/24, at 12:29 p.m. the Director of Nursing confirmed the facility failed to implement a bowel protocol as ordered for one out of four residents. (Residents R126). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical record review, observations, and staff interview, it was determined that the facility failed to provide pressure ulcer treatment consistent with professional standards of practice for one of two residents (Resident R130). Findings include: Review of facility policy Wound Prevention last reviewed 10/1/23, indicated residents will receive skin care, repositioning to assist in preventing the development of avoidable pressure ulcers. It was indicated a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. The resident's care plan will identify the resident as being at risk for pressure ulcers and provide aggressive/appropriate preventive measures and care specific to addressing the resident's. Review of the admission record indicated Resident R130 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and high blood pressure. Review of Resident R130's facility's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE], indicated the resident was a score of 20, and was not at risk for developing a pressure ulcer. Review of Resident R130's care plan dated 4/7/24, indicated to complete the Braden Scale weekly times 4 on an admission/readmission, quarterly, and with a significant change. The resident's care plan failed to include the resident's pressure ulcer. Resident R130's Minimum Data Set (MDS-periodic assessment of care needs) dated 4/24/24, indicated the diagnoses were current. Section M: Skin Conditions indicated the resident had four Stage 2 pressure ulcers (partial thickness loss of top layer of skin presenting as a shallow open ulcer, or may present as an intact or open/ruptured blister.) It was indicated one of the four pressure injuries were present upon admission. Review of Resident R130's clinical record from 4/15/24, through 4/29/24, failed to reveal a weekly Braden Scale assessment was completed as the care plan indicated. Review of Resident R130's physician order dated 4/21/24, indicated every week, starting 4/28/24, day shift, the nurse must measure the resident's stage two pressure ulcers. Review of Resident R130's clinical record failed to indicate a weekly wound assessment was completed as ordered on 4/28/24. During an interview on 5/1/24, at 12:17 p.m., Case Coordinator, Employee E6 confirmed the facility did not complete a weekly Braden Scale assessment from 4/15/24, through 4/29/24, and the facility failed to complete a weekly wound assessment as ordered for Resident R130. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code:211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical records, observations and staff interviews it was determined that the facility failed to ensure that residents received neurological assessments after an incident involving an unwitnessed fall for one of four residents (Residents R14). Findings include: The facility Neurological Assessment - Using the Flowsheet policy dated 1/7/22, last reviewed 2024, indicated that a neurological review flowsheet will be initiated in the electronic medical record or as a paper form and completed for all residents who have sustained head trauma, either from a fall or act in which the resident is struck on the head. It was indicated the form must be completed every 15 minutes for one hour, every two hours for the next six hours, and then every shift for 48 hours. Review of Residents R14's admission record indicated she was admitted on [DATE], and last readmitted on [DATE]. Review of Residents R14's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 2/7/24, indicated she had diagnoses that included a history of stroke a brain injury caused by a lack of oxygen to a group of brain cells), syncope and collapse (medical term for fainting or passing out), and seizure disorder (a condition where brain cells malfunction and send electrical signals uncontrollably). The assessment indicated that the diagnoses were still current upon review. Review of Residents R14's care plan dated 4/4/24, indicated she was at risk of falls. Review of Residents R14's clinical nurse note dated 3/11/24, at 11:10 am indicated the resident self-transferred from her recliner to her bathroom and was found sitting on the bathroom floor. Review of Residents R14's clinical record and assessments did not include a neurological assessment (Post incident assessment of resident's response and symptoms) for Resident R14's unwitnessed fall that occurred on 3/11/24. Review of Resident R14's clinical nurse note dated 3/13/24, at 11:17 a.m. indicated the resident was found in front of her wheelchair. Review of Residents R14's clinical record and assessments did not include a neurological assessment for Resident R14's unwitnessed fall that occurred on 3/13/24. Review of Residents R14's clinical nurse note dated 3/18/24, at 5:40 p.m. it was indicated the resident was found lying on the floor in front of her bed. Resident stated that she was walking to her dresser. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Residents R14's clinical record and assessments did not include a neurological assessment for Resident R14's unwitnessed fall that occurred on 3/18/24. Review of Resident R14's clinical nurse note dated 3/22/24, at 11:27 a.m. indicated the resident was found sitting on the floor with back against the wall next to recliner. It was stated the resident is non-compliant with transfer status. Review of Residents R14's clinical record and assessments did not include a neurological assessment for Resident R14's unwitnessed fall that occurred on 3/22/24. During an interview on 5/2/24, at 9:38 a.m. the Director of Nursing stated if a resident hits their head or has an unwitnessed fall, neurological assessments must be documented in the resident's electronic record under assessments. During an interview on 5/2/24, at 10:03 a.m. Registered Nurse (RN), Employee E9 stated if a residents has an unwitnessed fall, a nurse must complete an assessment immediately, ask the resident what happened, and if unwitnessed neurological checks must be completed. RN, Employee E# stated: if we find a resident on the floor, it is considered a fall, and neuro checks must be implemented. During an interview on 5/2/24, at 10:18 a.m. the DON confirmed that the facility failed to ensure that Resident R14 received neurological assessments after an incident involving unwitnessed falls as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(d) Resident care policies.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care related to oxygen management for three of three residents (Residents R2, R77, and R133). Findings include: Review of the facility's Respiratory Care Equipment Changed Policy dated 12/1/20, last reviewed 2024, indicated humidification must be labeled with the resident's name, room number, and date. It was indicated tubing will be changed weekly and dated and initialed. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE], with diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), high blood pressure, and renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids). Review of Resident R2's physician order dated 4/15/24, indicated to administer oxygen via nasal cannula (oxygen tubing) at 2-4 liters/minute. During an observation on 4/30/24, at 9:59 a.m. R2 was observed wearing 2L of oxygen. The oxygen tubing was not dated. Review of the clinical record revealed that Resident R77 was admitted to the facility on [DATE], with diagnoses of heart failure, renal insufficiency, and chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe). Review of Resident R77's physician order dated 4/20/24, indicated to administer oxygen via nasal cannula at 3 liters/minute. During an observation on 4/30/24, at 11:58 a.m. R77 was observed wearing 3L of oxygen. The oxygen tubing was not dated. During an interview on 4/30/24, at 12:00 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed that Resident R2 and Resident R77's oxygen tubing was not dated. Review of the clinical record revealed that Resident R133 was admitted to the facility on [DATE], with diagnoses of heart failure, pneumonia, and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high.) Review of Resident R133's physician order dated 4/30/24, indicated to administer oxygen via nasal cannula as needed at 2-4 liters/minute for hypoxemia (low blood oxygen). During an observation on 4/30/24, at 11:30 a.m. Resident R133 was observed wearing 2L of oxygen with humidification. The oxygen tubing and humidification was not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/24, at 11:34 a.m. Registered Nurse, Employee E7 confirmed Resident R113 oxygen tubing and humidification was not dated. During an interview on 5/2/24, at 2:00 p.m. the Director of Nursing confirmed the facility failed to provide appropriate respiratory care related to oxygen management for three of three residents (Residents R2, R77, and R133). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis center for two of two residents reviewed (Residents R76 and 130). Findings include: Review of the facility policy Dialysis Care Policy for Skilled Facility Residents dated 5/1/24, indicated the center staff will communicate with the dialysis (the clinical purification of blood by dialysis as a substitute for the normal function of the kidney) facility with any changes in weight or fluid gain. Review of the clinical record indicated that Resident R76 was admitted to the facility on [DATE], with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and stroke (damage to the brain from an interruption of blood supply). Review of R76's current physician orders on 4/18/24, indicated dialysis on Tuesday, Thursday, and Saturday. Review of Resident R7's care plan dated 4/18/24, indicated the resident will have no signs and symptoms of complications from dialysis. Review of Resident R7's Hemodialysis Communication Forms indicated six forms to be incomplete on 4/18/24, 4/20/24, 4/23/24, 4/25/24, 4/27/24, and one form without a date. During an interview on 4/30/24, at 2:12 p.m. Registered Nurse (RN) Employee E7 confirmed the dialysis communication forms were incomplete on the six dates above. Review of the admission record indicated Resident R130 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and high blood pressure. Review of R130's current physician orders on 3/29/24, indicated starting on 4/5/24, the resident will have dialysis on Monday, Wednesday, and Friday. Review of Resident R130's care plan dated 4/7/24, indicated the resident will have no signs and symptoms of complications from dialysis. Review of Resident R130's Hemodialysis Communication Forms indicated five forms to be incomplete on 4/19/24, 4/22/24, 4/24/24, 4/26/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/23, at 2:11 p.m. Unit Clerk, Employee E10 indicated dialysis communication sheets are filled out and must be placed in the resident's dialysis binder when they return from dialysis. Unit Clerk, Employee E10 confirmed Resident R130's Hemodialysis were not completed for five of six forms. Interview on 5/2/24, at 2:00 p.m. the Director of Nursing confirmed the facility failed to provide consistent and complete communication with the dialysis center for two of two residents reviewed (Residents R76 and 130). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 201.18(b)(e)(1)(2) Management 28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, and interview with staff, it was determined that the facility failed to make certain that PRN (as needed) orders for psychotropic medications are limited to 14 days for two of five sampled residents (Resident R3 and R13). Findings include: Review of the facility policy PRN Psychotropic Drugs dated 1/7/22, last reviewed in 2024, indicated all PRN psychotropic medications, excluding anti-psychotic drugs will have a time limitation of 14 days duration for orders. The exception indicated orders may be extended beyond 14 days if the prescriber believes that it is appropriate for the PRN order to be extended and must document their rationale in the medical record. No exceptions for antipsychotic drugs, they are limited to 14 days and cannot be renewed without explanation and a new order. Review of Resident R3's admission record indicated they were admitted on [DATE], with diagnoses that included stroke (damage to the brain from an interruption of blood supply), hemiplegia (paralysis of one side of the body), and atrial fibrillation (irregular heart rhythm). Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 1/26/24, indicated that the diagnoses were current upon review. Review of Resident R3's care plan dated 2/20/24, indicated that Resident R3 used psychotropic medications and will not have any side effects from the psychotropic medicine. Review of Resident R3's physician orders dated 11/6/23, indicated to administer alprazolam (an anxiety medication) by mouth every twenty-four hours as needed for anxiety without a cut date of 14 days as required. Further review of physician orders indicated a discontinued date of 1/3/24, exceeding the 14-day duration maximum requirement. Review of Resident R13's admission record indicated they were admitted on [DATE], with diagnoses that included dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, and depression. Review of Resident R13's MDS dated [DATE], indicated that the diagnoses were current upon review. Review of Resident R13's current care plan on 5/2/24, indicated resident will be administered psychotropic/psychoactive medication(s) as ordered and will be monitored for side effects and effectiveness. Periodically, resident will be assessed for the possibility dose reduction(s) or elimination of these medications as appropriate. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R13's physician orders 3/5/24, at 11:54 a.m. dated Olanzapine (antipsychotic medication) 2.5 mg (milligrams) tablet PRN, One Time Daily, without a cut date of 14 days as required. Further review of physician orders indicated a discontinued date of 5/1/24, at 7:37 p.m. which exceeded the 14-day duration maximum requirement. During an interview on 5/2/24, at 11:59 a.m. the Nursing Home Administrator confirmed that the facility failed to make certain that PRN medication orders for psychotropic medications are limited to 14 days for two of five sampled residents (Resident R3 and R13). 28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies.

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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 policy, observations and staff interview it was determined that the facility failed to date opened medications and properly store medications in one of two medication carts observed (Avalon medication cart). Findings include: Review of facility policy Insulin Administration - Insulin Pens dated 1/19/17, last reviewed in 2024, indicated check the expiration date of the insulin pen. If opening a new insulin pen, record expiration date, and time on the pen. Observation on 4/30/24, at 12:48 p.m. the Avalon medication cart indicated the following medications stored in the drawer without a date and time on the insulin pens, indicating date opened as required: -Resident R2's Victoza pen (injectable medicine used to help lower blood sugar), -Resident R76's Humalog quick pen (a short acting, manmade version of human insulin), and -Resident R126's Novolog Flex Pen (rapid acting insulin). Interview on 4/30/24, at 12:49 p.m. Licensed Practical Nurse (LPN) Employee E2 verified the findings noted above. Interview on 5/2/24, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to date opened medications and properly store medications in one of two medication carts observed (Avalon medication cart). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46336 Based on review of facility documents and staff interview, it was determined that the facility failed to make certain that the Medical Director and Infection Control Coordinator was in attendance, at least quarterly, at Quality Assurance Process Improvement (QAPI) Committee meetings for two of four quarters (May 2023 - July 2023, and November 2023 - January 2024). Findings include: A review of the facility policy Quality Assurance Process Improvement (QAPI) dated 12/1/21, last reviewed in 2024, indicated that the facility's QAPI Committee would include the Infection Control Coordinator and the Medical Director/designee on a quarterly basis. Review of QAPI Committee meeting sign-in sheets for the period of May 2023, through April 30, 2024, indicated that the Medical Director or physician designee was not in attendance for the quarterly meetings on November 2023, December 2023, or January 2024 quarterly meetings, and the Infection Preventionist was not present on 5/9/23, 6/30/23, or 7/31/23, 8/31/23, 9/29/23, 11/30/23, December 2023, and January 2024 were not available, as the Director of Nursing was also the Infection Preventionist. During an interview on 5/1/24, at 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that the Medical Director and Infection Control Coordinator was in attendance, at least quarterly, at Quality Assurance Process Improvement (QAPI) Committee meetings for two of four quarters (May 2023 - July 2023, and November 2023 - January 2024). 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 201.18(b)(e)(1)(2) Management 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on facility policy, clinical record review, observation, and staff interviews, it was determined the facility failed to implement measures to prevent the potential for cross contamination during a dressing change and implement transmission based precautions as ordered for one of three residents (Resident R130). Findings include: Review of facility policy Infection Prevention and Control Program dated 12/1/20, last reviewed 2024, indicated hand washing/hand hygiene is the single most important means of preventing the spread of infection. It was indicated hand washing/hand hygiene must be completed between environmental surface contacts, in between residents, and when otherwise indicated to avoid transfer of microorganisms to the residents and environments. Review of facility policy Clostridium Difficile dated 12/1/20, last reviewed 2024, indicated the facility will promote maximum protection for the residents, employees, and visitors against C. diff. As soon as a resident displays signs and symptoms of C. Diff or is admitted with the diagnosis of C. Diff, contact isolation will be initiated. It was indicated an isolation sign is posted on the door and isolation supplies are available at the entrance of the door. Review of the admission record indicated Resident R130 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependence on dialysis (a blood purifying treatment given when kidney function is not optimum), and high blood pressure. Resident R130's Minimum Data Set (MDS-periodic assessment of care needs) dated 4/24/24, indicated the diagnoses were current. Review of Resident R130's physician order dated 4/5/24, indicated to implement contact precautions continuously for Clostridium difficile (Infection of the large intestine (colon) caused by the bacteria Clostridium difficile) and VRE (stands for vancomycin-resistant enterococcus. It's an infection with bacteria that are resistant to the antibiotic called vancomycin). Review of Resident R130's physician order dated 4/21/24, indicated to cleanse blister to left lower extremity with normal saline, cover with telfa (cotton pads with a non-adherent coating that prevent sticking to the wound and promote healing) and wrap with kling (a type of self-adherent wrap that is commonly used in medical settings to secure dressings), once a day. During an observation on 4/30/24, at 2:18 p.m. no contact precautions or personnel protective equipment were observed outside of Resident R130's room as ordered. During an interview on 4/30/24, at 2:20 p.m. Registered Nurse, Employee E7 indicated the resident was on vancomycin when he was readmitted , however he has no diarrhea so he does not need contact precautions anymore. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a dressing change observation on 4/30/24, at 2:23 p.m. Registered Nurse (RN) Employee E7 did not perform hand hygiene and don a new pair of gloves after removing the resident's soiled dressing, prior to cleaning the wound, and applying a new clean dressing. During an interview on 4/30/24, at 2:40 p.m. Nursing Home Administrator confirmed the facility failed to implement measures to prevent the potential for cross contamination during a dressing change for Resident R130. During an interview on 5/1/24, at 11:08 a.m. Nurse Aide, Employee E14 stated residents on isolation precautions usually have signs posted on door and isolation cart outside room. If ordered isolation, and it's not on the resident's door, staff should consult an RN for next steps. During an interview on 5/1/24, at 11:12 a.m. the Director of Nursing (DON) stated Resident R130 should not be on contact precautions anymore and stated the contact precautions should have been discontinued. The DON confirmed the facility failed to implement transmission based precautions as ordered for one of three residents (Resident R130). 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396149	A. Building B. Wing	05/02/2024

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46337 Based on review of facility policy, infection control documentation and staff interviews, it was determined that the facility failed to have one or more individuals serving as the Infection Preventionist for twelve of twelve months (May 2023, June 2023, July 2023, August 2023, September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, March 2024, April 2024, and May 2024.) Findings include: Review of facility policy Infection Prevention and Control Program dated 12/1/20, last reviewed 2024, indicated the facility employs a full-time registered nurse that serves as the Infection Control Coordinator/Infection Preventionist. Review of the facility's undated Infection Preventionist Timeline failed to reveal an Infection Preventionist that was not the Director of Nursing (DON) or interim DON from 5/5/23, through 5/2/24. During an interview on 4/30/24, at 9:19 a.m. the Nursing Home Administrator indicated the DON was the Infection Preventionist (IP). During an interview on 5/2/24, at 11:02 a.m. the DON stated the facility has no part-time Infection Preventionist and she acts as the IP while working as the DON. The DON confirmed that the facility failed to have one or more individuals serving as the Infection Preventionist for twelve of twelve months. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)Nursing services.