STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395390	A. BLDG: 00 B. WING:	12/06/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NOTTINGHAM VILLAGE STATE LICENSE NUMBER: 401002	58 NEITZ ROAD PO BOX 32 NORTHUMBERLAND, PA 17857

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, and Civil Rights Compliance Survey, completed on December 6, 2024, it was determined that Nottingham Village was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0558 SS=D		F 0558		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	1. Resident 108 call bell corrected, care plan that she prefers it on the side of affected limb. 2. DON/Designee to do a sweep of residents to make sure call bells accessible to resident. 3. DON/Designee will educate nursing staff about call bell accessibility, policy and on 483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 4. DON/Designee will do a random audit weekly x4 and monthly x3 to ensure call bell placement. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0558 SS=D	Continued from page 2 Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to accommodate resident needs regarding the accessibility of a call bell for one of 23 residents reviewed (Resident 108). Findings include: Clinical record review for Resident 108 revealed the facility admitted her on September 19, 2024, with diagnosis including hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (a serious condition that occurs when brain tissue dies due to lack of blood flow to the brain) affecting the right dominant side. Interview with Resident 108 on December 3, 2024, at 11:23 AM revealed that she has limited range of motion to her right side following her stroke. Observation of Resident 108 on December 3, 2024, at 11:26 AM and 1:14 PM revealed Resident	F 0558		

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F 0558 SS=D	Continued from page 3 108 was in bed with her call bell attached to the top of the assist bar rail at the head of her bed. Resident 108 was unable to reach her call bell. Observation of Resident 108 on December 4, 2024, at 11:17 AM revealed Resident 108 was again in bed with her call bell attached to the top of the assist bar rail at the head of her bed. Resident 108 was unable to reach her call bell. The above information for Resident 108 was reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on December 5, 2024, at 2:22 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0558		
F 0607 SS=D		F 0607		

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F 0607 SS=D	Continued from page 4 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 0607	1. Resident 28 has a completed Incident Report and investigation summary regarding the unknown Fracture. 2. DON / Designee will audit the past 30 Incident / Accident reports to determine if other injuries of unknown origin have been investigated properly 3. DON/Designee will educate nursing Staff on making sure that incidents of unknown origin are resolved and abuse has been ruled out, and abuse prohibition policy. 4. DON/Designee will do a random audit weekly x4 and monthly x3 of Incident Reports to validate complete investigation including to rule out abuse for injuries of unknown origin. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0607 SS=D	Continued from page 5 This REQUIREMENT is not met as evidenced by:	F 0607		

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F 0607 SS=D	Continued from page 6 Based on clinical record review, review of select policies and procedures, and staff interview, it was determined that the facility failed to implement their abuse policy regarding completion of an investigation of an unknown injury for one of one resident reviewed (Resident 28). Findings include: The policy entitled "Abuse Prohibition" last reviewed on July 18, 2024, indicates that the facility uses an incident reporting system to report, investigate, and track all unusual incidents. Incidents of unknown origin are investigated according to the facility's stand-up meeting/investigation of unusual incidents. Suspicious injuries, occurrences, trends, or patterns that may constitute abuse are identified and investigated. Review of Resident 28's clinical record revealed nursing documentation dated September 26, 2024, at 2:30 PM that indicated Resident 28 was complaining of right leg pain. Nursing staff	F 0607		

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F 0607 SS=D	Continued from page 7 administered Tylenol (for pain relief) that was ineffective and notified Resident 28's physician. Nursing documentation dated September 27, 2024, at 2:30 PM indicated that Resident 28 continued to complain of pain in her right lower extremity from her hip to ankle. Nursing staff obtained a physician order for an x-ray of her right knee. Review of Resident 28's x-ray report dated September 27, 2024, indicated that her right knee demonstrated irregularity suggesting a tibial plateau fracture (a break at the top of the tibia bone in the knee joint, typically due to impact trauma). Nursing documentation dated September 28, 2024, at 2:04 AM revealed that the facility obtained a physician's order to send Resident 28 to the emergency room for treatment of her injury. Review of the emergency room documentation dated September 28, 2024, at 3:07 AM confirmed Resident 28's right knee tibial plateau fracture and	F 0607		

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F 0607 SS=D	Continued from page 8 indicated that her diagnosis also included ligamentous knee injury (a tear or sprain in one of the knee's four major knee ligaments). Nursing documentation dated September 28, 2024, at 11:00 AM revealed that Resident 28 returned from the emergency room with a right leg immobilizer (a splint used to keep stabilize or restrict movement of the leg). There was no documented evidence or incidents noted in Resident 28's clinical record to indicate how this injury occurred. Interview with the Director of Nursing on December 5, 2024, at 9:08 AM confirmed that the facility did not complete an investigation into Resident 28's fractured tibial plateau fracture to rule out the potential for abuse and neglect. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights	F 0607		

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F 0641 SS=D	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	1. MDS for Resident 108 has been modified to reflect impairment , Resident 112 MDS modified to reflect correct discharge placement 2. DON / Designee will audit recent MDS completed in the past 30 days to identify other potential inaccuracies. 3. DON/Designee will educate RNACs on 483.20(g) Accuracy of Assessments 4. DON/Designee will do a random audit weekly x4 and monthly x3 to accuracy of MDS assessments Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0641 SS=D	Continued from page 10 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure assessments accurately reflected residents' status for two of 23 residents reviewed (Residents 108 and 112). Findings include: Clinical record review for Resident 108 revealed the facility admitted her on September 19, 2024, with diagnosis including hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (a serious condition that occurs when brain tissue dies due to lack of blood flow to the brain) affecting her right dominant side. Interview with Resident 108 on December 3, 2024, at 11:23 AM revealed that she has limited range of motion to her right side following her stroke. Further review of Resident 108's clinical record revealed an admission MDS (Minimum Data Set, an	F 0641		

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F 0641 SS=D	Continued from page 11 assessment tool completed at specific intervals to determine resident care needs) dated September 25, 2024, in which facility staff assessed Resident 108 as having no impairment of her upper extremities. Interview with the Director of Nursing on December 5, 2024, at 10:22 AM confirmed Resident 108's functional limitation in her range of motion was coded in error on the MDS dated September 25, 2024. Review of Resident 112's clinical record revealed an MDS dated September 21, 2024, that indicated the facility assessed him as being discharged to a hospital setting. Nursing documentation dated September 21, 2024, at 10:35 AM revealed that the facility discharged Resident 112 to his home. Interview with the Director of Nursing on December 5, 2024, at 10:23 AM confirmed that Resident	F 0641		

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F 0641 SS=D	Continued from page 12 112's September 21, 2024 MDS was coded in error regarding his discharge status. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0641		
F 0684 SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Resident 68 care plan, orders were updated to reflect the pacemaker being present 2. There are no other current residents in the Center with a pacemaker who would be affected by the deficient practice 3. Nursing staff will be educated on 483.25 and making sure that resident with cardiac medical devices are care planned and ordered. 4. DON/Designee will do a audit weekly x4 and monthly x3 to assure that any residents with pacemakers have orders and care plans as appropriate. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0684 SS=D	Continued from page 13 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure quality of care related to a cardiac pacemaker use for one of 23 residents reviewed (Resident 68). Findings include: Interview with Resident 68 on December 4, 2024, at 11:14 AM revealed that she had a history of heart disease, and that she had a cardiac pacemaker (medical device implanted in the chest with wires to the heart to deliver electrical signals to control a heart rate) placed. Resident 68 pointed to an electronic device on her bedside stand and stated that a representative from the pacemaker monitoring company calls the nurses' station when she begins to show signs that fluid is accumulating in her body. Resident 68 stated that her Lasix (diuretic medication, used to remove excess fluid from the body) is sometimes adjusted because of this symptom change.	F 0684		

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F 0684 SS=D	Continued from page 14 Clinical record review for Resident 68 revealed no physician orders or plan of care that indicated that Resident 68 had a cardiac pacemaker. Diagnoses listed in Resident 68's clinical record included the following: Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (ongoing failure of the heart to pump effectively that results in fluid buildup in the body that can worsen suddenly requiring treatment) Paroxysmal atrial fibrillation (irregular heartbeat in the upper part of the heart that can be intermittent) An admission physician's progress note (history and physical) dated July 18, 2024, indicated that the facility admitted Resident 68 following a hospitalization for heart failure. The documentation noted a surgical history that included heart ablation (sections of the heart are surgically treated to stop abnormal electrical signals, Ablate Heart Dysrhythm Focus). The documentation indicated that Resident 68 had an, "AICD (automatic implantable	F 0684		

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F 0684 SS=D	Continued from page 15 cardioverter defibrillator, battery-operated device that can provide electrical impulses to maintain a normal rhythm and provide electrical shocks to the heart to correct life-threatening fast rhythms) per her records." The surveyor reviewed the above concerns that Resident 68 had an internal cardiac pacemaker; however, her physician orders and plan for her care did not address the use of this device, during an interview with the Director of Nursing and the Nursing Home Administrator on December 5, 2024, at 2:00 PM. A physician's order (following the surveyor's questioning) dated December 5, 2024, at 4:37 PM noted that Resident 68 had an, "ACID and HF Integration," completed for alerts and every 91 days as scheduled by a consulting cardiology provider. The cardiology provider monitors and would notify the facility of any issues. Interview with the Director of Nursing on December	F 0684		

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F 0684 SS=D	Continued from page 16 6, 2024, at 10:07 AM confirmed that Resident 68's cardiac pacemaker device could identify a potential fluid accumulation around her heart for which the monitoring company would call the facility. The facility was unaware how this device communicates with the monitoring company (e.g., via satellite, internet, cell phone); or what emergency procedures (e.g., power supply) would be necessary to continue its functioning when the facility would experience an interruption in utilities. The interview also confirmed that the device was not addressed in Resident 68's plan of care. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0688 SS=D		F 0688		

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	395390	A. BLDG: __00_____ B. WING: _____	12/06/2024

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F 0688 SS=D	Continued from page 17 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. Resident 108 to be re-evaluated by therapy to make sure appropriate for RNP program to the lower extremities. 2. DON / Designee will audit the past 30 days of therapy discharges to an RNP to identify if other residents been affected. 3. DON/Designee will educate Therapy on 483.25(c) (3), and policy named Restorative Policy 4. Rehabilitation supervisor/Designee will do an audit weekly x4 and monthly x3 to assure that RNP programs were communicated with nursing staff to implement. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0688 SS=D	Continued from page 18 Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to implement a restorative nursing program as recommended by therapy to ensure a resident with limited range of motion received appropriate treatment and services to increase and/or prevent further decrease in range of motion for one of three residents reviewed (Residents 108). Findings include: Clinical record review for Resident 108 revealed the facility admitted her on September 19, 2024, with diagnosis including hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following a cerebral infarction (a serious condition that occurs when brain tissue dies due to lack of blood flow to the brain) affecting right dominant side. Interview with Resident 108 on December 3, 2024, at 11:23 AM revealed that she has limited range of motion to her right side following her stroke. She	F 0688		

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F 0688 SS=D	Continued from page 19 stated that she no longer receives physical therapy. Review of Resident 108's admission Minimum Data Set (MDS, an assessment completed at specific intervals to determine care needs) dated September 25, 2024, noted Resident 108 had impairment on one side of her lower extremity. Review of physical therapy documentation dated November 8, 2024, noted the discharge recommendations for Resident 108 was for staff to complete passive range of motion (PROM) and active range of motion (AROM) exercises to both Resident 108's lower extremities to maintain ability for clothing management and daily hygiene tasks. Therapy discharge documentation noted therapy established PROM/AROM exercises and trained staff. Further review of Resident 108's clinical record revealed no evidence that staff implemented PROM or AROM programs.	F 0688		

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F 0688 SS=D	Continued from page 20 Interview with Employee 5 (physical therapist) on December 6, 2024, at 10:30 AM confirmed that a range was motion program was never established for Resident 108, and nursing staff were not educated. The above findings for Resident 108 were reviewed with the Director of Nursing on December 6, 2024, at 1:12 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0688		
F 0698 SS=D		F 0698		

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F 0698 SS=D	Continued from page 21 483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	1. Resident 62 care plan updated, special instructions updated, and order placed not to use right arm for BP, veni-punctures. 2. Currently there are no other dialysis patients in the Center that could be potentially affected by the same deficient practice. 3. DON/Designee will educate nursing staff on 483.25(1), and policy Dialysis 4. DON/Designee will do an audit weekly x4 and monthly x3 to assure that all new dialysis residents have appropriate orders and care plans for affected limbs related to fistulas. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0698 SS=D	Continued from page 22 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement care to prevent potential complications from a dialysis access site for one of one resident reviewed for dialysis services (Resident 62). Findings include: Interview with Resident 62 on December 3, 2024, at 12:58 PM revealed that he required dialysis treatments (treatment for kidney failure; a machine filters extra fluid and waste products from the blood) three times a week, and that the treatment was administered through a fistula (surgical connection between an artery and a vein making a larger blood vessel for dialysis treatment) located in the area over his right bicep (upper arm) muscle. Resident 62 stated that staff obtain blood pressure assessments from his leg. Resident 62 stated, "Once in a while a nurse will come in and think that she's going to take it in my arm, but I tell her to do it in my leg." Observation of Resident 62 and his room during the	F 0698		

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F 0698 SS=D	Continued from page 23 interview revealed no indicators that Resident 62 had right arm use restrictions. Clinical record review for Resident 62 revealed no physician's order or plan of care intervention that restricted staff use of his right arm for blood pressure assessments or blood draws. The surveyor reviewed the above concern that staff could utilize Resident 62's right arm inappropriately causing potential damage to his dialysis fistula during an interview with the Nursing Home Administrator and the Director of Nursing on December 4, 2024, at 2:00 PM. Interview with the Director of Nursing on December 5, 2024, at 10:40 AM confirmed that the right arm limb restriction was not included in Resident 62's plan of care until following the surveyor's questioning. Observation of Resident 62's room on December 6, 2024, at 9:15 AM revealed that Resident 62 was	F 0698		

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F 0698 SS=D	Continued from page 24 out of the facility for his dialysis treatment. A sign above the right side of his bed noted, "No BP (blood pressure) right arm." 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0698		
F 0700 SS=E		F 0700		

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F 0700 SS=E	Continued from page 25 483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F 0700	1. Resident # 19 has been assessed for need, consented on the risk and benefits, and an entrapment inspection completed for her bed positioning device. Resident #108 no longer has bed positioning devices. 2. DON / designee will conduct sweep to determine if other residents using siderails or positioning devices have a current assessment of need, risk and benefits consent, and a completed entrapment inspection on record. 3. Licensed Nurses and Rehab Staff will be educated on CFR Code 483.25(n) and the Center's policy regarding bedrail use in a skilled nursing facility. 4. DON / designee will conduct weekly sweeps to validate resident's using bedrails or bed positioning devices have documented evidence of assessment of need, risk and benefit consent, current entrapment risk inspection. Audit will be conducted weekly x 4 weeks, and then monthly x 3 months. Results of the audits will be submitted to the	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0700 SS=E	Continued from page 26	F 0700	QAPI team. 5. Date of Compliance 1/30/2024	

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F 0700 SS=E	Continued from page 27 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to obtain consent for, assess the need for, and assess entrapment risks from bed assistive bars for two of two residents reviewed for accident hazards (Residents 19 and 108). Findings include: Observation of Resident 19 on December 4, 2024, at 11:52 AM revealed she was in bed with assist bars mounted bilaterally at the head of her bed. Resident 19's bed was also equipped with a headboard and a footboard. The surveyor requested evidence of an assessment for need, an assessment for entrapment risks, and consent for the use of the bed assistive devices for Resident 19 during an interview with the Director of Nursing, the Nursing Home Administrator, and Employee 8 (registered nurse/infection control prevention coordinator) on December 4, 2024, at 2:00 PM.	F 0700		

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F 0700 SS=E	Continued from page 28 Interview with the Nursing Home Administrator on December 5, 2024, at 10:10 AM indicated that the facility utilized a bed system measurement device to assess four zones of potential entrapment risks presented with the use of a bed rail. The interview indicated that the facility could not provide documentation of the assessment completed to determine Resident 19's need for the assistive device, the assessment of potential entrapment risks from the use of the device on Resident 19's bed, or a consent obtained prior to installation of the device for Resident 19. A new physician's order obtained on December 5, 2024, at 11:04 AM (following the surveyor's questioning), indicated that Resident 19 was to use a bed enabler rail to assist with bed mobility. A Side Rail Assessment Form dated December 5, 2024, indicated that occupational therapy staff recommended side rails as an enabler for Resident 19. A Side Rail Consent Form signed by Resident	F 0700		

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F 0700 SS=E	Continued from page 29 19 on December 5, 2024, indicated a desire for the assistive device. A Bed System Measurement Device Test Results Worksheet dated December 5, 2024, indicated that maintenance staff assessed Resident 19's bed assistive device for entrapment risks. Clinical record review for Resident 108 revealed the facility admitted her on September 19, 2024, with diagnosis including hemiparesis (a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (a serious condition that occurs when brain tissue dies due to lack of blood flow to the brain) affecting right dominant side. Interview with Resident 108 on December 3, 2024, at 11:23 AM, revealed that she has limited range of motion to her right side following her stroke. Observation of Resident 108 on December 3, 2024, at 11:26 AM and 1:14 PM, revealed she was in bed with assist bars mounted bilaterally at the head of her bed.	F 0700		

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F 0700 SS=E	Continued from page 30 Observation of Resident 108 on December 4, 2024, at 11:17 AM revealed she was in bed with assist bars mounted bilaterally at the head of her bed. Observation of Resident 108 on December 5, 2024, at 11:01 AM revealed she was in bed, and the assist bars were removed bilaterally from the head of her bed. Interview with the Nursing Home Administrator on December 5, 2024, at 11:57 AM confirmed that Resident 108 was unable to use the bilateral assist bars mounted on her bed. He stated the facility had no documentation of the assessment completed to show the need for Resident 108's assist bars, the assessment of potential risks from the use of the device on Resident 108's bed, or consent obtained prior to the installation of the device for Resident 108. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0700		

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F 0725 SS=D	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 0725	1. Resident 52 call bell answered at the time of need, Resident 19 made sure all needs are met. 2. DON/Designee will do a random audit of residents to make sure that call bells are being answered timely to see if any other residents affected. 3. DON/Designee will educate nursing staff on 483.35(a), and policy named call bells 4. DON/Designee will do an audit weekly x4 and monthly x3 to assure call bells are being answered timely and all needs have been met of the resident. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0725 SS=D	Continued from page 32 Based on observations, clinical record review, and resident and staff interview, it was determined that the facility failed to have sufficient nursing staff to meet resident's needs related to call bell response time for two of 23 residents reviewed (Resident 19 and 52). Findings include: Interview with Resident 19 on December 4, 2024, at 11:34 AM revealed that when she rings her call bell, staff will come in and then say they will be back but never come back. Review of Resident 52's Minimum Data Set Assessment (MDS, an assessment tool completed at specific intervals to determine care needs) dated November 11, 2024, indicated the facility assessed her as being cognitively intact and needing the extensive assistance of two staff members for toileting. Observation on December 3, 2024, at 9:54 AM	F 0725		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
NOTTINGHAM VILLAGE STATE LICENSE NUMBER: 401002	58 NEITZ ROAD PO BOX 32 NORTHUMBERLAND, PA 17857

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0725 SS=D	Continued from page 33 revealed that Resident 52 rang her call bell. The call bell continued to ring until 10:26 AM, 32 minutes after Resident 52 initiated the call bell. At 10:26 AM, Employee 1, nurse aide, entered Resident 52's room, the call light went out, and Employee 1 immediately walked back out of Resident 52's room. Interview with Resident 52 on December 3, 2024, at 10:29 AM revealed that she "needed to move her bowels" and "needed the bed pan" but Employee 1 "flew out of here." This surveyor instructed Resident 52 to ring the call bell again. After Employee 1 exited Resident 52's room, this surveyor observed her collecting breakfast trays. Employee 1 was not providing any other care to residents. Observation on December 3, 2024, at 10:29 AM revealed that Resident 52's call bell was answered a second time, 35 minutes after Resident 52's initial call for assistance.	F 0725		

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F 0725 SS=D	Continued from page 34 Review of Resident 52's clinical record revealed that she has a diagnosis of irritable bowel syndrome (a condition that affects the digestive system). Nursing documentation dated December 2, 2024, at 4:40 PM indicated that Resident 52 had not had a bowel movement for three days. Nursing staff administered Milk of Magnesia (a medication used to treat occasional constipation) on December 2, 2024, at 6:31 PM. Interview with the Administrator and Director of Nursing on December 5, 2024, at 2:00 PM acknowledged the above findings for Resident 52. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(3)(4)(5) Nursing services	F 0725		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 35 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. Medication cart was locked at the time of the finding, Resident 29 eye drops (expired) were dis-guarded and obtained new. 2. There are no other residents to protect in a similar situation 3. DON/Designee will educate nursing staff on Labeling and storage of Drugs and Biologicals. 4. DON/Designee will do an audit weekly x4 and monthly x3 to assure that medication carts are locked, and medications are appropriately stored. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0761 SS=D	Continued from page 36 Based on observation and staff interview, it was determined that the facility failed to ensure adequate labeling and storage of medications and biologicals on one of three nursing units (Station III) and for one of 23 residents reviewed (Resident 29). Findings include: Observation of the Station III nursing unit on December 3, 2024, at 10:41 AM revealed an unlocked medication cart. The medication cart was sitting in a heavily occupied area of the nursing station. The unlocked medication cart was accessible to non-licensed staff, visitors, and other residents. The unlocked medication cart remained unattended until 10:46 AM. Interview with Employee 3, licensed practical nurse, on December 3, 2024, at 10:46 AM confirmed the above observations. During a medication administration observation on December 3, 2024, at 9:00 AM revealed Employee	F 0761		

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F 0761 SS=D	Continued from page 37 2, licensed practical nurse, administering medications to Resident 29. Employee 2 indicated that Resident 29 administers her own eye drops. Employee 2 prompted Resident 29 to find her eye drops and administer them during the medication administration observation. Resident 29 reached into a zippered pouch that contained other items such as writing implements and pulled out a bottle of eyedrops. The bottle of eyedrops had some small brown colored stains on it, and the label was rubbing off. The eyedrops were not labeled with the resident's name or administration details. This surveyor was unable to identify that actual name of the eyedrops, other than it was a saline eye drop. Resident 29 could not remove the lid to the eyedrops, as the lid appeared stuck. Employee 2 had to assist Resident 29 to remove the stuck lid. The bottle of eye drops had an expiration date of September 2023. Resident 29 administered the eyedrops using the bottle of eyedrops she found in her zippered pouch.	F 0761		

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F 0761 SS=D	Continued from page 38 Employee 2 then told Resident 29 that those eyedrops were expired after the surveyor informed her of the expiration date. Interview with the Administrator and Director of Nursing on December 5, 2024, at 2:03 PM acknowledged the above findings. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services	F 0761		
F 0791 SS=E		F 0791		

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F 0791 SS=E	Continued from page 39 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 0791	1. Resident 62 to have dental cleaning by dental professional 2. DON / Designee will audit current residents who resided in the Center during the past 12 months to identify those who may have not received a dental cleaning. 3. DON/Designee will educate nursing staff on 483.55(b) 4. DON/Designee will conduct random audits weekly X 4 weeks and then monthly X 3 months to validate residents have received or have been offered dental cleaning in prior 12 months. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0791 SS=E	Continued from page 40 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 0791		

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F 0791 SS=E	Continued from page 41 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure routine prophylactic dental services for one of three residents reviewed for dental concerns (Resident 62). Findings include: Interview with Resident 62 on December 3, 2024, at 12:49 PM revealed that he had natural teeth, but the, "hygienist has never been here." Resident 62 indicated that no dental professional had cleaned his teeth, and he brushes his teeth. Interview with the Director of Nursing on December 5, 2024, at 10:40 AM confirmed that there was no evidence that a hygienist or dental professional provided prophylactic (preventative) cleaning of Resident 62's teeth in the past year. Following the interview with the Director of Nursing, the facility provided one progress note from the facility's consulting dental provider dated September 17, 2024, that was noted as an annual exam by the	F 0791		

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F 0791 SS=E	Continued from page 42 dentist. The progress note indicated that there was heavy soft plaque/food debris buildup, light hard calculus (hard deposit when soft plaque becomes calcified) deposits, moderate gingival (gum) inflammation/swollen bleeding gums, and moderate risk for caries (cavities/decay). The recommended treatment plan was for prophy (preventative cleanings) every six months. The facility provided no clinical record evidence that Resident 62 received routine prophylactic dental cleanings in the past year. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0791		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 43 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. No residents were affected by deficient practice. Expired food items have been discarded; surfaces found to have dust and debris have been cleaned; other issues found have been resolved. Employee # 7 counselled for failing to wear beard guard. 2. Administrator / designee will conduct a kitchen inspection to determine if other expired food items exist; storage of items on bottom shelves have lining protection; equipment, vents, and other surfaces are free from dust / stains / debris; staff are wearing proper hair restraining devices. 3. Administrator / designee will conduct training with all Dietary personnel on CFR 483.60 (i)(1)(2) and the Center's Policy regarding Food Procurement / Storage / Sanitation 4. Administrator / designee will monitor for compliance by conducting routine kitchen audit inspections at least weekly x 4 weeks and then monthly x 3 months. Results of the inspections will be submitted to the QAPI team.	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0812 SS=E	Continued from page 44	F 0812	5. Date of Compliance 1/30/2024	

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F 0812 SS=E	Continued from page 45 Based on observation and staff interview, it was determined that the facility failed to store food items and maintain equipment in a safe and sanitary manner in the facility's main kitchen. Findings included: Initial tour of the facility's main kitchen on December 3, 2024, between 7:55 AM and 9:00 AM revealed the following: The dry storage goods area revealed the following: A bag of elbow macaroni had a blank date sticker on it and contained no open or use by date. There was a hole in the bottom of the bag. A temperature control unit on the wall had a significant accumulation of a black substance on the vents. An open container of whole rosemary had an expired use date of May 2024.	F 0812		

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F 0812 SS=E	Continued from page 46 An open container of blue food coloring had an unreadable use by sticker. The bottle was hand dated "1-30-19." The walk-in freezer contained several cardboard boxes that held food items (snickerdoodle dough, whipped topping, and cherry turnovers) that were located under the internal circulation fans. The boxes had a large accumulation of ice on them. A walk-in cooler contained eight cardboard boxes that held orange juice containers. The boxes noted, "store at 0 degrees Fahrenheit." Three boxes observed were stamped by the facility with a date of November 8, 2024, and one box had a date of October 30, 2024. A concurrent interview with Employee 6, Dietary Manager, revealed the dates indicated when the items were pulled from the freezer to thaw for use. A review of the manufacturer's instructions for the items revealed the items come frozen, thaw before serving, mark each case with the date the product was thawed, once	F 0812		

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F 0812 SS=E	Continued from page 47 thawed the items are to be kept refrigerated, and once thawed they are to be used within 10 days of thawing. The orange juice was not used within 10 days of thawing. Further observation of the walk-in cooler revealed a low-fat cottage cheese with an expired use by date of "12/2," and two open bags of cubed cheese that had an expired facility use by date of "12-2-24." Observation of a second walk-in cooler revealed the following: Several clear containers of pudding with expired facility use by dates of December 1, 2024, and December 2, 2024. A thawed box of hot dogs with a facility use by date of "11/30/24." A container of hot dog chili sauce with a manufacturer's use by/freeze by date of November 29, 2024.	F 0812		

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F 0812 SS=E	Continued from page 48 Two containers of baked lima beans with an expired use by date of November 24, 2024. A large bag of shredded lettuce with an expired use by date of November 30, 2024. Two coated wire storage racks of items located near the center of the kitchen, that Employee 6 identified as clean, had items stored on the bottom shelves (one rack had various baking pans; the other rack had large black colored storage tubs and plate lids). There was no protective covering to protect these clean items on the bottom shelf from mop splash during floor cleaning. A green colored plastic tray in the sink next to the dishwasher had an extensive build-up of a black colored substance on it. A temperature control unit located on the wall in the food prep area had visible dust on it and a black colored build-up on the vents.	F 0812		

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F 0812 SS=E	Continued from page 49 The tops of the commercial coffee machine and juice machine had an accumulation of dust. Observation revealed an employee at a food prep area with a beard and no facial hair restrainer (beard guard). The employee was identified by administrative staff as Employee 7, dietary staff, and revealed the employee should have a beard cover. The above findings were reviewed with Employee 6 at the time of the findings. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on December 4, 2024, at 2:50 PM. 483.60(i) Food Procure, Store/Prepare/Serve -Sanitary Previously cited 1/5/24 28 Pa. Code 201.14(a) Responsibility of licensee	F 0812		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0848 SS=E	483.70(m), 483.70(m)(2)(iii)(iv)(6) Binding Arbitration Agreements §483.70(m) Binding Arbitration Agreements. If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by:	F 0848	1. Residents #19, 62 and 68 have been offered a new arbitration agreement which meets compliance. 2. Administrator / Designee will conduct a sweep of all current in-house residents to identify who has a signed arbitration agreement not meeting the required language. 3. Administrator / designee will contact NV legal representatives to seek assistance in reconstructing an Arbitration Agreement that meets regulatory requirement. A regulatory compliant arbitration agreement will be re-offered to all current residents / patient reps. 4. Administrator / designee will conduct random audits of new admissions, weekly x4 weeks and then monthly x 3 months. Results of the audits will be submitted to the QAPI team. 5. Date of Compliance 1/30/2025	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0848 SS=E	Continued from page 51 Based on review of the facility's arbitration agreements and staff interview, it was determined that the facility's arbitration agreements failed to ensure a neutral and fair arbitration process by ensuring the selection of a neutral arbitrator for three of three residents reviewed with a signed arbitration agreement (Residents 19, 62, and 68). Findings include: Review of an "Agreement to Resolve Disputes by Voluntary Mediation and/or Mandatory Binding Arbitration," (an agreement that the resident/resident's responsible party and the facility will resolve legal disputes through binding arbitration, waiving the right to a trial) signed by Resident 19 on February 22, 2023, revealed that the document stipulated that, "Subject to Section 6 of this Agreement, the Arbitration shall be administered by (name of arbitrator services company designated by the facility)." "In the event (name of arbitrator services company designated by the facility) is unable or	F 0848		

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F 0848 SS=E	Continued from page 52 unwilling to serve, then the request for Arbitration must be submitted to the Facility within thirty (30) days of receipt of notice of (name of arbitrator services company designated by the facility) unwillingness or inability to serve as a neutral arbitrator. The parties shall mutually select an alternative neutral arbitration service within thirty (30) days thereafter." The agreement afforded the facility the selection of the arbitrator (third-party decision-maker contracted to resolve a dispute) initially unless the facility-selected arbitrator could not provide the services. Resident 62 signed an arbitration agreement with the same verbiage on April 20, 2023. Resident 68 signed an arbitration agreement with the same verbiage on July 15, 2024. The surveyor reviewed the above concerns regarding the arbitration agreements signed by	F 0848		

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F 0848 SS=E	Continued from page 53 Residents 19, 62, and 68 during an interview with the Nursing Home Administrator and the Director of Nursing on December 4, 2024, at 2:00 PM. Interview with the Nursing Home Administrator on December 5, 2024, at 10:10 AM confirmed that the facility's current arbitration agreement did not stipulate that both parties would agree upon a neutral arbitrator unless the arbitrator that was selected by the facility was unable or unwilling to provide the services. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a)(j) Resident rights	F 0848		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 54 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Resident 103, has no current active infection, contact precautions not needed, Resident 103 does not have targeted MDRO and elimination is contained and covered as described by QSO-24-08-NH so no enhanced barrier precautions are needed. Policy "enhanced barrier precautions" to be updated to make sure reflect proper QSO guidance on enhanced barrier precautions. 2. There are no other residents to protect in a similar situation 3. DON/Designee will educate Infection Control Preventionist (IP) on 483.80(a)(1)(2)(4)(e)(f) and QSO-24-08-NH. 4. DON/Designee will do an audit weekly x4 and monthly x3 to assure that residents are on the appropriate precautions. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0880 SS=D	Continued from page 55 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 56	F 0880		

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F 0880 SS=D	Continued from page 57 Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to implement transmission-based precautions for one of 23 residents reviewed (Resident 103). Findings include: Review of the facility policy, "Contact Precautions," last reviewed without changes on July 18, 2024, revealed that in addition to standard precautions, use contact precautions for specified residents known or suspected to be infected with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident care activities that require touching the resident's dry skin) or by indirect contact (touching) with environmental surfaces or resident care items in the patient's environment. In addition to wearing a gown as outlined under standard precautions, wear a gown when entering the room if you anticipate that your clothing will have	F 0880		

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F 0880 SS=D	Continued from page 58 substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the resident is incontinent. A sign will be posted at the resident's doorway to indicate to visitors that they should check with the nurse before entering to ensure proper precautions are followed. A physician's order will be obtained and written when placing a resident on precautions and when precautions can be discontinued. Review of the facility policy, "Enhanced Barrier Precautions," last reviewed without changes on July 18, 2024, revealed that enhanced barrier precautions will be initiated for any resident with an infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply. A sign will be posted at the resident's doorway to alert staff. A physician's order will be obtained and written when placing a resident on enhanced barrier precautions. Providers and staff must also wear gloves and gowns for high contact activities that include changing briefs or assisting with toileting.	F 0880		

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F 0880 SS=D	Continued from page 59 Clinical record review for Resident 103 revealed nursing documentation dated September 9, 2024, at 2:10 PM that the facility readmitted Resident 103 from the hospital. A physician's order dated September 9, 2024, instructed staff to administer Cephalexin (Keflex, a first-generation cephalosporin antibiotic, refers to the first group of cephalosporins discovered), every six hours for Resident 103's urinary tract infection, for five days. A laboratory report for a urine specimen collected September 9, 2024, revealed that Resident 103's urine indicated an infection with ESBL E-Coli (extended-spectrum beta-lactamases Escherichia coli, bacteria typically found in the gut that produces a chemical that makes some antibiotics ineffective in treating the bacterial infection), "This patient may require isolation. This gram-negative bacilli displays in vitro (experiments outside a living organism) resistance to multiple antibiotics. This patient may	F 0880		

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F 0880 SS=D	Continued from page 60 require isolation." The report indicated that the E-Coli found was resistant to Cefazolin (a first-generation cephalosporin). Nursing documentation dated September 13, 2024, at 7:44 PM indicated that the physician ordered the antibiotic, Cipro, to treat Resident 103's urinary tract infection (UTI). "Resident 103 received the antibiotic, Keflex, previously." Review of a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated November 6, 2024, assessed Resident 103 as always incontinent of bowel and bladder. There was no evidence in Resident 103's clinical record to indicate that the facility implemented any isolation precautions for Resident 103 upon her readmission to the facility or after the final laboratory report that indicated an infection with a multiple drug resistant organism (MDRO).	F 0880		

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F 0880 SS=D	Continued from page 61 Review of plans of care developed by the facility to address Resident 103's care needs revealed a plan of care that included Resident 103's urinary tract infection diagnosis that did not include the implementation of contact or enhanced barrier precautions. Observation of Resident 103 on December 5, 2024, at 12:41 PM revealed she was in bed, with covers pulled down to her thighs, dressed in a shirt and an incontinence brief (no pants). Interview with the Director of Nursing on December 5, 2024, at 12:50 PM confirmed that the facility did not have evidence of the implementation of enhanced barrier or contact precautions upon the knowledge of a MDRO UTI for Resident 103. The facility also did not have any additional laboratory testing that indicated the absence of the MDRO in Resident 103's urine. Interview with Employee 9 (nurse aide) on December 5, 2024, at 12:55 PM confirmed that	F 0880		

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F 0880 SS=D	Continued from page 62 Resident 103 was incontinent of bowel and bladder, and dependent upon staff for care, which included the use of incontinence briefs. Employee 9 stated that she was going to provide Resident 103 incontinence care for the first time since earlier that morning. Employee 9 did not use an isolation gown to indicate the use of enhanced barrier or contact precautions. There was no indication by Resident 103's doorway or in her room that indicated the use of enhanced barrier or contact precautions. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 1/5/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0880		
F 0883 SS=D		F 0883		

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F 0883 SS=D	Continued from page 63 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 0883	1. Resident 3 family contacted to see if they receive consent if they want the influenza vaccine. 2. Infection Control Preventionist (IP) /designee to do audit to make sure that all consents for influenza for current residents have either been received back or contact to determine administration. 3. DON/Designee will educate Infection Control Preventionist (IP) on 483.80(d)(1)(2) 4. Infection Control Preventionist (IP) /Designee will do an audit weekly x4 and monthly x3 to make sure new residents have determination of influenza vaccine. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0883 SS=D	Continued from page 64 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 65 Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to offer and administer an influenza immunization unless refused for one of five residents reviewed for immunizations (Resident 3). Findings include: The facility policy entitled, "Influenza Vaccine," last reviewed without changes on July 18, 2024, revealed that residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. Between October 1st and October 31st each year, the influenza vaccine shall be offered to residents unless the vaccine is medically contraindicated, or the resident has already been immunized. Prior to vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine.	F 0883		

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	395390	A. BLDG: __00_____ B. WING: _____	12/06/2024

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NOTTINGHAM VILLAGE STATE LICENSE NUMBER: 401002	58 NEITZ ROAD PO BOX 32 NORTHUMBERLAND, PA 17857

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F 0883 SS=D	Continued from page 66 Provision of such education shall be documented in the resident's medical record. For those who receive the vaccine, the date of vaccination will be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. Current CDC (Centers for Disease Control) guidance at https://www.cdc.gov/flu/vaccines stipulates that, "For most people who need only one dose of influenza vaccine for the season, September and October are generally good times to be vaccinated against influenza. Ideally, everyone should be vaccinated by the end of October." Clinical record review for Resident 3 revealed that the facility admitted her on May 13, 2022. Review of Resident 3's immunization history revealed that she received an influenza immunization on January 14, 2022 (before entering the facility), and October 25, 2023 (while a resident of the facility). Resident 3's clinical record contained no evidence that she	F 0883		

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F 0883 SS=D	Continued from page 67 received an influenza vaccine for the 2024-2025 influenza season. The surveyor requested any additional immunization documentation for Resident 3 during an interview with Employee 8 (registered nurse/infection control prevention coordinator) on December 4, 2024, at 9:26 AM. Interview with Employee 8 on December 4, 2024, at 10:37 AM confirmed that Resident 3 was a resident in the facility for over two years, and that the facility could not produce an informed consent for the influenza vaccine since the one completed in 2023. The interview confirmed that the facility did not have evidence that Resident 3 or her responsible party declined the 2024-2025 influenza vaccine. The surveyor reviewed the above concerns regarding Resident 3's influenza vaccination status during an interview with the Director of Nursing and the Nursing Home Administrator on December 5, 2024, at 2:00 PM.	F 0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0883 SS=D	Continued from page 68 Interview with Employee 8 on December 5, 2024, at 2:49 PM confirmed that there was no documentation in Resident 3's medical record regarding declination or administration of the 2024-2025 seasonal influenza vaccine. Employee 8 stated that she would attempt to find any progress note documentation regarding any contact with Resident 3's responsible party regarding obtaining consent or refusal of the vaccine. Nursing documentation created by Employee 8 on December 5, 2024, at 3:12 PM indicated that she attempted to contact Resident 3's responsible party regarding vaccine consents. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0883		
F 0887 SS=D		F 0887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0887 SS=D	Continued from page 69 483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;	F 0887	1. Resident 3 family contacted to see if they receive consent if they want the COVID-19 vaccine. 2. Infection Control Preventionist (IP) /designee to do audit to make sure that all consents for COVID-19 vaccine for current residents have either been received back or contact to determine administration. 3. DON/Designee will educate Infection Control Preventionist (IP) on 483.80 (d)(3)(i)-(vii) COVID-19 Immunization 4. Infection Control Preventionist (IP) /Designee will do an audit weekly x4 and monthly x3 to make sure new residents have determination of COVID-19 vaccine. Results of the inspections will be submitted to the QAPI team. 5. Date of compliance 1/30/25	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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F 0887 SS=D	Continued from page 70 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by:	F 0887		

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F 0887 SS=D	Continued from page 71 Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to offer and administer a COVID immunization for one of five residents reviewed for immunizations (Resident 3). Findings include: The facility policy entitled, "Coronavirus Disease (COVID-19) - Vaccination of Residents," last reviewed without changes on July 18, 2024, revealed that each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. The resident (or resident representative) could accept or refuse a COVID-19 vaccine, and to change his/her decision. COVID-19 vaccine education, documentation, and reporting are overseen by the infection preventionist and coordinated by his or her designee. Before the COVID-19 vaccine is offered, the resident/resident representative is provided with education regarding	F 0887		

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F 0887 SS=D	Continued from page 72 the benefits, risks, and potential side effects associated with the vaccine. Residents/resident representatives must sign a consent to vaccinate form prior to receiving the vaccine. Booster vaccine doses are provided in accordance with current CDC guidance. Efforts to help the resident obtain vaccination are documented. If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination or refusal, appropriate documentation is made in the resident's record. Clinical record review for Resident 3 revealed that the facility admitted her on May 13, 2022. Review of Resident 3's immunization history revealed that she did not receive a COVID (a contagious respiratory illness caused by a virus) immunization booster in the fall of October 2023, because Resident 3's responsible party refused the immunization consent. Nursing documentation dated August 17, 2024, at 3:11 PM revealed that testing indicated Resident 3	F 0887		

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F 0887 SS=D	Continued from page 73 had COVID and the facility implemented isolation precautions. On October 25, 2024, Employee 8, registered nurse/infection control, documented that Resident 3 was not eligible for a COVID booster for 2024-2025 because the facility did not have consent to administer the vaccine. Resident 3's clinical record contained no additional information that the facility offered or administered Resident 3's COVID immunization after October 2023. Interview with Employee 8 on December 4, 2024, at 9:26 AM indicated that the facility did not administer a COVID booster to Resident 3 because Resident 3's responsible party refused the consent to the vaccine. Employee 8 stated that she would provide the consent form that documented Resident 3's responsible party's declination of informed consent.	F 0887		

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F 0887 SS=D	Continued from page 74 Interview with Employee 8 on December 4, 2024, at 10:37 AM confirmed that Resident 3 did not receive any COVID vaccines since her admission to the facility in 2022. The interview also confirmed that the facility could not produce an informed consent for the COVID vaccine that evidenced that Resident 3's responsible party declined the booster vaccine. The surveyor reviewed the above concerns regarding Resident 3's COVID immunization status during an interview with the Director of Nursing and the Nursing Home Administrator on December 5, 2024, at 2:00 PM. Interview with Employee 8 on December 5, 2024, at 2:49 PM confirmed that there was no documentation in Resident 3's medical record regarding declination or administration of a COVID booster immunization since 2023. Employee 8 stated that she would attempt to find any progress note documentation regarding any contact with Resident 3's responsible party regarding obtaining	F 0887		

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F 0887 SS=D	Continued from page 75 consent or refusal of the vaccine. Nursing documentation created by Employee 8 on December 5, 2024, at 3:12 PM indicated that she attempted to contact Resident 3's responsible party regarding vaccine consents. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0887		

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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	1. No residents were affected by the deficient practice. 2. There are no other residents to protect in a similar situation 3. The IDT / ABX Stewardship and Infection Control Committee will be educated on the ACT 52 requirement specifically regarding required member participation. 4. Administrator / designee will audit the 4th quarter ABX Stewardship / Infection Control Committee to validated attendance by all required members per the ACT 52 Standard. 5. Date of Compliance 1/30/2025	Completion Date: **01/30/2025** Status: **APPROVED** Date: **12/18/2024**

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

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P 1020	Continued from page 1 Based on staff interview and review of facility documentation, it was determined that the facility did not comply with the multidisciplinary committee requirements of the Act 52 Infection Control Plan. Findings include: Act 52 Infection Control Plan, states that a health care facility should develop and implement an internal infection control plan that should be established for the purpose of improving the health and safety of residents and health care workers and should include a multidisciplinary committee including a representative from each of the following, if applicable to the specific health care facility: (i) Medical staff that could include the chief medical officer or the nursing home medical director (ii) Administration representatives that could include the chief executive officer, the chief financial officer, or the nursing home administrator (iii) Laboratory personnel (iv) Nursing staff that could include a director of	P 1020		

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P 1020	Continued from page 2 nursing or a nursing supervisor (v) Pharmacy staff that could include the chief of pharmacy (vi) Physical plant personnel (vii) A patient safety officer (viii) Members from the infection control team, which could include an epidemiologist. (ix) The community, except that these representatives may not be an agent, employee, or contractor of the health care facility. The surveyor requested infection control committee meeting attendance during an interview with the Nursing Home Administrator on December 3, 2024, at 7:49 AM. Review of the provided Infection Control Meeting attendance forms dated January 18, 2024, through October 17, 2024, revealed that there was no evidence that a physical plant representative (maintenance staff) participated in the meetings. Interview with Employee 4 (maintenance director)	P 1020		

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P 1020	Continued from page 3 on December 4, 2024, at 10:15 AM confirmed that he had not attended any infection control committee meetings. Employee 4 confirmed that upon his review of attendance signatures, there was no evidence that anyone from the maintenance department attended the meetings. Interview with the Nursing Home Administrator and the Director of Nursing on December 5, 2024, at 2:00 PM confirmed the absence of required members at infection control committee meetings per the available attendance documentation.	P 1020		

Certified End Page

NOTTINGHAM VILLAGE

STATE LICENSE NUMBER: 401002

SURVEY EXIT DATE: 12/06/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY