STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395396	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
EDENBROOK SOUTH STATE LICENSE NUMBER: **641502**	**101 LEADER DRIVE** **WILLIAMSPORT, PA 17701**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, and Civil Rights Compliance Survey completed on January 24, 2025, it was determined that Williamsport South Rehabilitation and Nursing Center 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 as they relate to the Health portion of the survey process.	F 0000		
F 0550 SS=D		F 0550		

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 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	Cited: Resident 61's Catheter bag was placed in a cover and moved to the non- hallway side of the bed.  Like: Residents requiring the use of a urinary catheter were audited to ensure the catheter bags were covered and placed on the non-hallway side of the bed.  Education: DON/designee will educate nursing staff catheter bags being in covers and on non-hallway side of the beds.  Audits: DON/designee will audit residents with catheter bags to ensure they are in covers and placed on non-hallway sides of the bed. Audits will be completed weekly x4 weeks then monthly x 2 months. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550		

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F 0550 SS=D	Continued from page 3 Based on observation and staff interview, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of 21 residents sampled (Resident 61). Findings include: Observation on January 21, 2025, at 10:42 AM revealed Resident 61 was sleeping in bed. Observation from the hallway revealed Resident 61's catheter bag was full of urine, not covered, and laying on the floor. Observation on January 22, 2025, at 10:36 AM revealed Resident 61 was sleeping in bed. Observation from the hallway revealed Resident 61's catheter bag was again not covered and laying on the floor. The surveyor reviewed the above findings during a meeting with the Director of Nursing on January 24, 2025, at 9:34 AM.	F 0550		

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F 0550 SS=D	Continued from page 4 CFR 483.10(a) Resident Rights/Exercise of Rights. Previously cited deficiency 2/16/24. 28 Pa. Code 201.18(b)(1) Management	F 0550		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 5 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	Cited: Resident 85 and resident 56 feeding pump pole was cleaned. Resident 68 and resident 14's rooms and bathroom were cleaned to ensure free of urine odor. Resident 39's night stand handles were repaired by maintenance director. Items in resident 39's room were organized. Resident 50's cove base was repaired in his room behind the head of the bed.  Like: Feeding pumps and poles facility wide were cleaned. Resident rooms and bathrooms facility wide were cleaned to ensure free of urine odor. Resident room floors were cleaned and resident room cove basing and walls were cleaned and repaired as needed.  Education: NHA/designee will educate the environmental staff on ensuring feeding poles and pumps and resident rooms and bathrooms are properly	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0584 SS=D	Continued from page 6 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	cleaned. NHA/designee will educate maintenance department on ensuring handles of night stands and wall and cove basing are repaired appropriately.  Audits: Environmental Director/designee will audit 5 random resident rooms and bathrooms to ensure cleanliness as well as odor weekly x 4 weeks and monthly x2 months. Maintenance director/designee will audit 5 night stands and 5 resident rooms weekly x4 weeks then monthly x 2 months to ensure night stands are appropriate as well as cove basing and walls. Results will be taken through QAPI.	

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F 0584 SS=D	Continued from page 7 Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to maintain a clean and safe environment on four of four nursing units (North, South, East and West, Residents 85, 56, 68, 14, 39, and 50). Findings include: An observation of Resident 85 on January 21, 2025, at 10:28 AM revealed the resident was in bed. An enteral feeding pump was observed hanging from the pole beside the resident's bed, not in use. The feeding pump was observed to have several spots of dried brown liquid splatter/spills on the exterior of the feeding pump. There was no enteral feeding bag/container hanging at the time of the observation. Resident 85's observation of the feeding pump was reviewed with the Director of Nursing on January 22, 2025, at 2:30 PM.	F 0584		

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F 0584 SS=D	Continued from page 8 An observation of Resident 56 on January 21, 2025, at 11:01 AM revealed the resident was in bed. An enteral feeding pump and bag was observed hanging from a pole beside the resident's bed. The feeding pump was observed to have several spots of dried brown liquid splatter/spills on the exterior of the feeding pump, the pole, and the bagged supplies hanging from the pole. The above findings for Resident 56's feeding tube feed were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on January 22, 2025, at 2:12 PM. Observation of the West Nursing Unit on the following dates and times revealed the following: On January 21, 2025, at 11:30 AM there was a strong odor of urine in Resident 68's bathroom. On January 22, 2025, at 11:47 AM there was a strong odor of urine in Resident 68's room and the bathroom. At 12:02 PM there was a strong odor of	F 0584		

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F 0584 SS=D	Continued from page 9 urine in Resident 14's room. On January 23, 2025, at 11:56 AM there was a strong odor of urine in Resident 68's room. On January 24, 2025, at 10:57 AM there was a faint odor of urine in Resident 14's room. The surveyor reviewed this information during an interview with the Nursing Home Administrator and Director of Nursing on January 23, 2025, at 2:45 PM. Observation of Resident 39's room on January 22, 2025, at 10:13 AM revealed a strong urine smell, and the floor was dirty from his bed to the area at the bottom of his roommates bed. The wall to the left of the doorway was dirty. There were two night stands right inside the door to the left with an unorganized pile of stuff on top to include: briefs, clothes, books, CDs, O2 equipment, and Eucerin cream (used to treat dry skin). The first nightstand had the handle missing from the top drawer. The	F 0584		

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F 0584 SS=D	Continued from page 10 second nightstand had a broken handle hanging down from the second drawer. The wall to the right of the bed (when looking at the bed) and adjacent to the bathroom, was all marred and the paint was peeled near the bottom of the wall. Observation of Resident 50's room on January 24, 2025, at 10:45 AM revealed the cove base coming off the wall directly behind the head of Resident 50's bed. There were crumbled pieces of the wall on the floor that appeared to have come from the area where the cove base was missing. The Nursing Home Administrator and Director of Nursing were made aware of the concerns in Resident 39 and 50's rooms on January 24, 2024, at 11:30 AM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited 2/16/24, and 8/6/24 28 Pa. Code 201.14(a) Responsibility of licensee	F 0584		

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F 0607 SS=D	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. This REQUIREMENT is not met as evidenced by:	F 0607	Cited: Per follow up investigation, abuse and neglect was ruled out for resident 42. · Like: Facility will do a two week look back of injuries of unknown origin to ensure a full investigation was completed. · Education: DON/designee will educate nursing staff on the facility Abuse Policy and Procedure, Incident and Accident Investigations to ensure residents with injuries of unknown origins are fully investigated to rule out potentential abuse/neglect. · Audits: Residents with injuries of unknown origins will be audited weekly x4 then monthly x2 to ensure injuries are fully investigated. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0607 SS=D	Continued from page 12 Based on clinical record review, staff interview, and review of facility investigation documentation, it was determined that the facility failed to thoroughly investigate a resident's injury of unknown origin for one of two residents reviewed for abuse (Resident 42). Findings include: Clinical record review for Resident 42 revealed a progress note dated December 30, 2024, at 1:16 PM that indicated the nurse was made aware of Resident 42 having a bruise on the right side of her face that measured 3 centimeters (cm) x 2 cm and was dark bluish and purplish in color. The bruise was on the outside of the right eye. The note indicated that Resident 42 is combative with care and staff were educated to walk away when performing care if the resident becomes combative to avoid self-inflicted wounds. Further clinical record review revealed that there was no follow-up progress notes related to the	F 0607		

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F 0607 SS=D	Continued from page 13 event until January 22, 2025, at 5:49 PM after the surveyor inquired about event reports related to Resident 42 in a meeting on January 22, 2025, at 3:01 PM with the Director of Nursing. The note indicated that the registered nurse concluded her investigation and believed that Resident 42's bruise was consistent with her aggressively knocking her glasses off her face while having behaviors during care. The note also indicated that the staff were educated. Review of the facility's investigation into the event revealed that they did not obtain witness statements from staff related to how the injury may have occurred and there was no evidence of staff education. Interview with the Director of Nursing on January 23, 2025, at 2:55 PM revealed that she did not have witness statements from staff related to how the bruise may have occurred, or evidence that the staff were educated on interventions to implement when Resident 42 became combative and	F 0607		

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F 0607 SS=D	Continued from page 14 aggressive with care. The facility failed to thoroughly investigate Resident 42's injury of unknown origin. 483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Previously cited 5/22/2024. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights	F 0607		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 15 483.20(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	Step 1: Re-education on coding accuracy. Please obtain signatures of all applicable MDS coordinators from the facility (See attached Section N of the RAI Manual): Immediate Remedy and Re-education/MDS modification submitted by Regional Step 2: Audit most recently completed OBRA MDS Assessment 100% of current residents, any coding errors identified to be fixed. **See Audit tool. **Tip** You can pull an MDS item response specific for MDSs and how this question N0415E was coded- then review the MAR for that time frame. To be completed by Facility MDS Completed Audit to be reviewed by Regional MDS: Step 3: Continued Audit needs: 10 completed MDSs to be reviewed by 2nd MDS coordinator and/or regional. To be completed weekly x 4 weeks:	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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 0641 SS=D	Continued from page 16 Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 21 residents reviewed (Resident 52). Findings include: Clinical record review for Resident 52 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated November 6, 2024, that facility staff assessed Resident 52 as receiving an anticoagulant medication during the last seven days in the assessment period. Further clinical record review revealed no evidence that Resident 52 received an anticoagulant medication during the assessment period for the MDS noted above. Interview with the Director of Nursing on January 23, 2025, at 2:31 PM confirmed that Resident 52's November 6, 2024, MDS was coded in error	F 0641		

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F 0641 SS=D	Continued from page 17 regarding receiving an anticoagulant medication. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0641		
F 0677 SS=E	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Cited: Resident 65 and resident 89 bathing preferences were collected and honored.  Like: Facility wide sweep will be completed to ensure residents bathing preferences are honored.  Education: NHA/designee will educate staff on resident bathing preferences.  Audits: NHA/designee will audit 5 residents weekly x 4 weeks and monthly x2 months to ensure resident bathing preferences are being honored. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0677 SS=E	Continued from page 18 Based on clinical record review and staff interview, it was determined that the facility failed to provide activities of daily living (ADL) for two of five residents reviewed (Resident 65 and 89). Findings include: Clinical record review for Resident 65 revealed that the facility completed a significant change MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) on November 25, 2024, which indicated that it was somewhat important that they choose between a tub bath, shower, bed bath, or sponge bath. The MDS also identified that they were dependent on staff for a shower and to bathe themself. Review of Resident 65's task documentation (documentation where staff indicate completion of ADL care) revealed that since June 29, 2023, staff was to complete ADL - Bathing (bed bath) during the day shift on Tuesdays and Saturdays.	F 0677		

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F 0677 SS=E	Continued from page 19 Review of Resident 65's task documentation revealed that there was documentation that indicated staff provided the following showers to Resident 65: October 5 and 29, 2024 November 12, 19, 26, and 30, 2024 December 3, 7, and 31, 2024 January 7, and 11, 2025 Further review of Resident 65's task documentation revealed that staff documented "RR (resident refused)" or did not document that bathing was completed on the following dates: October 8, 2024 November 2 and 23, 2024 December 14, 17, and 21, 2024 January 18, 2025 There was no documentation that indicated staff re-approached, re-addressed bathing, or provided Resident 65 the opportunity to bathe the next shift	F 0677		

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F 0677 SS=E	Continued from page 20 or following day. Further review of Resident 65's task documentation revealed that staff indicated "No" they did not cleanse Resident 65's hair on bathing days or did not document completion of cleansing Resident 65's hair on the following dates: October 5, 2024, day shift October 8, 2024, evening shift November 2, 2024, evening shift November 23, 2024, day shift December 21, 2024, evening shift December 24, 2024, day and evening shift January 4, 7, and 18, 2025 Further review of Resident 65's task documentation revealed that staff documented "RR (resident refused)" or did not document that hair cleansing was completed on the following dates: October 5, 2024, evening shift October 8, 2024, day shift	F 0677		

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F 0677 SS=E	Continued from page 21 October 22, 2204, day and evening shift November 2, 2024, day shift November 23, 2024, evening shift December 21, 17, and 21, 2024 January 18, 2025 There was no documentation that indicated staff re-approached, re-addressed cleansing Resident 65's hair, or provided Resident 65 the opportunity to cleanse their hair the following day. Observation of Resident 65 on January 22, 2025, at 11:46 AM and January 23, 2025, 2:07 PM revealed that their hair was disheveled. The surveyor reviewed the above information during an interview with the Director of Nursing on January 24, 2025, at 8:57 AM Clinical record review for Resident 89 revealed that the facility admitted him on March 23, 2024, with diagnosis of dementia with behavioral disturbances and adult failure to thrive.	F 0677		

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F 0677 SS=E	Continued from page 22 Clinical record review for Resident 89 revealed current task documentation that he was independent to requiring transfer assistance and at times requires physical assistance with bathing/showers and personal hygiene. Review of Resident 89's task documentation revealed that staff were to complete his showers on Sundays and Thursdays during the day shift. Review of Resident 89's task documentation for November 2024, revealed that there was documentation that indicated staff provided him with a shower or bed bath on November 10, and November 21, 2024. Review of Resident 89's task documentation for December 2024, revealed that there was documentation that staff provided him with a shower or bed bath on December 8, 2024. Review of Resident 89's task documentation for	F 0677		

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F 0677 SS=E	Continued from page 23 January 1-19, 2025, revealed that there were no documented showers for him during that time period. Review of Resident 89's shower documentation for November 2024, revealed that he refused his shower on November 3, 7, 14, 17, 24, and 28, 2024. Review of Resident 89's shower documentation for December 2024, revealed that he refused his shower on December 1, 5, 12, 15, 19, 22, and 26, 2024, with no documentation on December 29, 2024. Review of Resident 89's shower documentation for January 1-19, 2025, revealed that he refused his shower on January 2, 5, 9, 12, and 16, with no documentation on January 19, 2025. There was no documentation that indicated staff re-approached, re-addressed bathing, or provided Resident 89 the opportunity to bathe the next shift	F 0677		

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F 0677 SS=E	Continued from page 24 or following day. Review of Resident 89's care plan revealed no interventions related to him refusing baths or showers. The surveyor reviewed the above information during an interview with the Director of Nursing on January 23, 2025, at 3:08 PM. 483.24(a)(2) Adl Care Provided for Dependent Residents Previously cite 9/12/24, 5/22/24, and 2/16/24 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0677		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 25 483.25 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	Cited: Resident 93 has orders regarding soaking hands and orders r4eflecting therapy to assist with hand therapy.  Like: The facility will do a two-week look back to ensure residents who attend appointments and return with follow up recommendations, that recommendations are timely addressed.  Education: DON/designee will educate nursing staff on ensuring appointment follow up recommendations are addressed timely.  Audits: DON/designee will audit 5 residents weekly x 4 weeks and monthly x2 months to ensure recommendations from resident appointments are followed up timely. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0684 SS=D	Continued from page 26 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure the highest practical care related to consultant recommendations for one of 21 residents reviewed (Resident 93). Findings include: Observation and interview with Resident 93 on January 21, 2025, at 10:51 AM revealed Resident 93 complained of a "cold hand." Observation of his right hand revealed he had no grasp, and his fingers were partially contracted. He stated that he sits on his hand to try and warm up his hand and straighten his fingers. Resident 93 stated that he went to see a specialist about his hand. Review of Resident 93's clinical record indicated he saw a plastic surgeon on January 13, 2025, due to pain and stiffness in his right hand. The physician progress note indicated with some exercise Resident 93's range of motion improved. The physician noted that the facility stopped doing occupational	F 0684		

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F 0684 SS=D	Continued from page 27 therapy even though he was improving. The physician recommended warm soaks twice a day and a need to resume hand therapy. Further review of Resident 93's clinical record revealed no documentation that the facility implemented the physician's recommendations. Interview with the Director of Nursing on January 24, 2025, at 11:06 AM confirmed these findings and stated the facility implemented the physician's recommendations after the surveyor's questioning. 483.25 Quality of Care Previously cited deficiency 2/16/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 28 483.25(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	Cited: Residents 42, 65, and 70 range of motion programs were reviewed with IDT team and were reevaluated by therapy.  Like: The facility will complete a two-week look back on residents who were discharged from therapy to review if resident is appropriate for ROM program and ensure it is initiated.  Educations: DON/designee will educate nursing staff and ensuring ROM program recommendations from therapy are followed appropriately.  Audits: DON/designee will audit 5 residents weekly x 4 weeks then monthly x 2 months to ensure residents who are discharged from therapy have appropriate ROM programs initiated if appropriate. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0688 SS=E	Continued from page 29 Based on clinical record review and staff interview, it was determined that the facility failed to provide services to maintain or improve a resident's range of motion (ROM) and mobility for three of seven residents reviewed (Residents 42, 65, and 70). Findings include: Clinical record review for Residents 65 revealed a current therapy restorative referral dated November 29, 2024. Therapy staff indicated nursing staff should provide seated AROM/AAROM (active and active assisted range of motion, movement of the body to maintain a resident's ability) one to two times daily for their LAQ's (bilateral anterior quadriceps, upper leg muscles) marches, heel to toes, hip abduction (legs move away from the body's midline), adduction (legs move towards the body's midline), and pillow squeezes. Review of Resident 65's task documentation revealed that nursing staff did not implement the AROM/AAROM the restorative nursing program	F 0688		

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F 0688 SS=E	Continued from page 30 until December 6, 2024, day shift. There was no documentation that staff completed or indicated "No" for Resident 65's AROM/AAROM restorative nursing program on the following dates: December 6. 15, 25, and 30, 2024 January 8, 13, 18, and 19, 2025 The surveyor reviewed the above information on January 24, 2025, at 11:44 AM with the Director of Nursing. Clinical record review for Resident 42 revealed a Minimum Data Set (MDS, an assessment completed by the facility at intervals to determine care needs of the resident) assessment dated December 5, 2024, that indicated she had an impairment on one side of her upper and lower extremities. Further clinical record review revealed no evidence that Resident 42 was receiving a ROM program. Review of Resident 42's physical therapy discharge	F 0688		

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F 0688 SS=E	Continued from page 31 information dated December 23, 2024, revealed that a restorative ROM program was established, and staff were trained for Resident 42 to have AROM/AAROM to bilateral lower extremities. Review of her occupational therapy discharge information dated December 20, 2024, revealed that a ROM program was established for her right upper extremity. Resident 42 was also to have a splint brace program for a carrot splint (a device placed in hand to prevent contractures) to be placed in her right hand at all times except for meals and activities of daily living. A restorative nursing program instruction form from physical therapy was sent to nursing on December 24, 2024, outlining the instructions for the program that was to be completed with Resident 42 related to her bilateral lower extremities. The program was never initiated until January 22, 2025, after the surveyor brought it to the attention of the Director of Nursing (DON) on the same date at 3:00 PM. The Nursing Home Administrator and the DON	F 0688		

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F 0688 SS=E	Continued from page 32 were made aware of the issues above related to Resident 42's ROM and splint programs on January 23, 2025, at 3:00 PM. Clinical record review for Resident 70 revealed an MDS assessment dated December 2, 2024, that indicated he had a limited ROM on one side of his upper and lower extremity. Further clinical record review revealed no evidence that he was receiving a ROM program. Review of Resident 70's physical therapy summary dated December 23, 2024, revealed that a ROM program was established for AROM to his bilateral lower extremities. A restorative nursing program instruction form from physical therapy was sent to nursing on December 24, 2024, outlining the instructions for the program that was to be completed with Resident 70 related to his bilateral lower extremities. There was no evidence that the program was ever initiated.	F 0688		

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F 0688 SS=E	Continued from page 33 The Director of Nursing confirmed on January 24, 2024, at 8:54 AM that the ROM program for Resident 70 was never initiated. The facility failed to provide services to maintain or improve range of motion for Residents 42, 65, and 70. 483.25(c)(1)-(3) Increase/prevent Decrease In Rom/mobility Previously cited 9/12/24 and 2/16/24 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0688		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 34 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	Cited: Resident 43's oxygen order was clarified. Resident 43's Bipap mask was placed in an appropriate bag.  Like: Facility-wide sweep was completed to ensure residents who have active oxygen orders are correctly being followed. Facility-wide sweep also completed to ensure appropriate respiratory supplies in stored in bags appropriately.  Education: DON/designee will educate nursing staff on ensuring oxygen orders are followed and respirate equipment is stored appropriately.  Audits: DON/designee will audit 5 residents per week x 4 weeks then monthly x 2 months to ensure oxygen orders are approraot3ely followed and that respiratory equipment is stored appropriately. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0695 SS=D	Continued from page 35 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of three residents reviewed (Resident 43). Findings include: According to the American Association for Respiratory Care proper cleansing of respiratory (nebulizer) equipment reduces infection risk. The longer a dirty nebulizer sits and is allowed to dry, the harder it is to clean thoroughly. Parts of the aerosol drug delivery device should be rinsed and then washed with soap and hot water after each treatment. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. Clinical record review for Resident 43 revealed a current physician's order for staff to provide oxygen at 5 liters per minute (LPM) via NC (nasal canula, tubing to deliver oxygen to the nose) continuously every day and evening shift for supplementary	F 0695		

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F 0695 SS=D	Continued from page 36 oxygen and BiPAP (pressurized non-invasive air ventilation via mask): oxygen 6 to 7 LPM at bedtime and as needed (PRN) for sleep apnea. Observation of Resident 43's oxygen concentrator on January 21, 2025, at 11:15 AM and January 22, 2025, at 11:52 AM and 3:20 PM revealed that their oxygen level was set at 9 LPM via NC and without humidification. Resident 43's BiPAP mask was unbagged and lying on the floor behind their oxygen concentrator during the January 21, 2025, observation and lying on their bedside stand during the January 21, 2025, observations. The surveyor reviewed the above information for Resident 43 during an interview with the Director of Nursing on January 22, 2025, at 3:20 PM. 483.25(i) Respiratory/tracheostomy Care and Suctioning Previously cited 2/16/24 28 Pa. Code 211.10 (c)(d) Resident care policies	F 0695		

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F 0695 SS=D	Continued from page 37 28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0695		
F 0726 SS=E	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 0726	Cited: Employees 4, 5, 6, and 7 completed the following competencies: enteral tube feeding, tracheostomy care, catheter care, medication administration, and dressing changes.  Like: HR/designee will complete audit of current employees to ensure appropriate competencies are completed.  Education: NHA/designee will educate the staff educator to ensure plan of current staff to obtain appropriate competencies.  Audits: Staff educator/designee will audit 5 employees including new hires weekly x 4 weeks then monthly x 2 months to ensure staff have appropriate competencies completed. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0726 SS=E	Continued from page 38 This REQUIREMENT is not met as evidenced by:	F 0726		

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F 0726 SS=E	Continued from page 39 Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with enteral tube feeding, tracheostomy care, catheter care, medication administration, and dressing changes for four of four employees reviewed for competencies (Employees 4, 5, 6, and 7). Findings include: A review of the facility documentation revealed that the facility had a total of 121 residents receiving medications, 10 residents with indwelling catheters (insertion of a tube into the bladder to remove urine), five residents with pressure ulcers, five residents with enteral tube feedings (device that allows liquid food to enter your stomach or intestine through a tube), and one resident with a tracheostomy (a surgical airway management procedure that consists of making an incision on the anterior aspect of the neck and opening a direct	F 0726		

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F 0726 SS=E	Continued from page 40 airway through an incision in the trachea). A request for nursing staff competencies for enteral tube feeding, tracheostomy care, catheter care, medication administration, and dressing changes revealed the facility was unable to provide any competencies for Employees 4 (registered nurse, RN), 5 (RN), 6 (licensed practical nurse, LPN), and 7 (LPN). The findings were reviewed with the Nursing Home Administrator and Director of Nursing on January 24, 2025, at 9:03 AM. Further interview with the Director of Nursing on January 24, 2025, at 10:15 AM confirmed the facility could provide no documentation that ensured Employees 4, 5, 6, and 7 have specific competencies and skill sets to care for the residents' needs listed above. 28 Pa Code 201.20(a) Staff development	F 0726		
F 0756 SS=E		F 0756		

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F 0756 SS=E	Continued from page 41 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	Cited: Residents 23, 42, and 49 pharmacy recommendations were reviewed by the physician with a response.  Like: The facility will complete a two-week look back to review pharmacy recommendations to ensure there is a physician response.  Education: DON/designee will educate the licensed staff to ensure responses are provided to pharmacy recommendations.  Audits: DON/designee will audit 5 reside pharmacy recommendations weekly x 4 weeks then monthly x 2 months to ensure physician response is provided. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0756 SS=E	Continued from page 42 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=E	Continued from page 43 Based on clinical record review and staff interview, it was determined that the facility failed to maintain pharmacy recommendations or evidence pharmacy recommendations were addressed by the physician for three of five residents reviewed (Residents 23, 42, and 49). Findings include: Clinical record review for Resident 23 revealed a pharmacist monthly medication review note dated June 10, 2024, which indicated a medication review was completed for the resident and to "see report for recommendation." There was no evidence of the pharmacist report of recommendations or a physician's response to a pharmacy recommendation for the date indicated. Interview with the Nursing Home Administrator and Director of Nursing on January 24, 2025, at 8:52 AM revealed the pharmacy recommendation for June 10, 2024, could not be located to determine if the physician addressed the recommendation.	F 0756		

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F 0756 SS=E	Continued from page 44 Clinical record review for Resident 49 revealed that the consultant pharmacist completed a medication review on November 10, 2024. There was no documentation what the consultant pharmacist recommended or that the physician or facility responded to the consultant pharmacist recommendations. This surveyor reviewed the above information during an interview with the Nursing Home Administrator on January 24, 2025, at 9:15 AM. Clinical record review for Resident 42 revealed a consultant pharmacist monthly medication review note dated June 10, 2024, which indicated a medication review was completed for the resident and to "see report for recommendation." There was no evidence of the pharmacist's report of a recommendation or a physician's response to a pharmacy recommendation for the date indicated. The Nursing Home Administrator and the Director	F 0756		

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F 0756 SS=E	Continued from page 45 of Nursing confirmed on January 24, 2025, at 8:54 AM that they could not locate the pharmacy recommendation from June 10, 2024. 483.45(c)(4) Pharmacy review Previously cited 2/16/24, and 5/22/24 28 Pa. Code 211.9 (d)(k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0756		
F 0758 SS=E		F 0758		

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F 0758 SS=E	Continued from page 46 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	 Cited: Resident 9 and resident 65 medication regime was reviewed and properly addressed by the physician.  Like: The facility will complete a medication regime review for current residents to ensure they are free for unnecessary medications directly related to physician recommendation to decrease Cymbalta and review of PRN antianxiety medication without supporting documentation.  Education: DON/designee will educate nursing staff to ensure the pharmacist and #39's recommendations are followed to avoid unnecessary medications as well as recommendation to decrease Cymbalta ad review of PRN anti-anxiety Medications without supporting documentation.  Audits: DON/designee will audit 5 random residents weekly x 4 weeks then monthly x 2 months to ensure the pharmacist resident 39's recommendations are followed to avoid unnecessary medications.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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F 0758 SS=E	Continued from page 47 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	Audit will also include recommendation to decrease Cymbalta ad review of PRN anti-anxiety Medications without supporting documentation. Results will be taken through QAPI.	

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F 0758 SS=E	Continued from page 48 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for two of five residents reviewed for medication regime review (Residents 9 and 65). Findings include: Clinical record review revealed the facility admitted Resident 9 on January 16, 2023. Review of the consultant pharmacist's recommendation dated July 13, 2024, revealed Resident 9 has been receiving Buspar (medication used to treat anxiety) 10 milligrams (mg) three times a day and Cymbalta (antidepressant medication) 90 mg every day. The consultant pharmacist requested the facility consider an attempted dose reduction or trial discontinuation. Resident 9's physician agreed to change her Cymbalta to 60 mg every day on July 24, 2024. Further review of Resident 9's clinical record revealed the facility never decreased her Cymbalta	F 0758		

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	395396	A. BLDG: __00_____ B. WING: _____	01/24/2025

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F 0758 SS=E	Continued from page 49 to 60 mg until January 17, 2025. Interview with the Nursing Home Administrator and Director of Nursing on January 24, 2025, confirmed these findings indicating the facility did not follow through with the physician's response to Resident 9's July 13, 2024's, consultant pharmacist recommendation. Clinical record review for Resident 65 revealed the following physician orders: Ativan (Lorazepam) 0.5 mg by mouth (PO) every 8 hours as needed (PRN) for anxiety, ordered on August 27, 2024, and discontinued on August 31, 2024. There was no stop date identified for this PRN psychotropic medication. Ativan 0.5 mg PO every 8 hours PRN for anxiety for 14 Days, ordered on August 31, 2024, and discontinued on September 3, 2024. Ativan 0.5 mg PO every 8 hours PRN for anxiety for 28 Days, ordered on September 3, 2024, and discontinued on October 1, 2024.	F 0758		

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	395396	A. BLDG: 00 B. WING:	01/24/2025

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EDENBROOK SOUTH STATE LICENSE NUMBER: **641502**	**101 LEADER DRIVE** **WILLIAMSPORT, PA 17701**

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F 0758 SS=E	Continued from page 50 Ativan 0.5 mg PO every 8 hours PRN for general anxiety disorder (GAD), ordered on October 7, 2024, 11:00 AM and discontinued on October 7, 2024, shortly thereafter. There was no stop date identified for this PRN psychotropic medication. Ativan 0.5 mg PO every 8 hours PRN for GAD for 30 Days, ordered on October 7, 2024, and discontinued on November 6, 2024. Lorazepam 0.5mg PO once for anxiety PRN, one time only for anxiety/behaviors for 1 day, ordered on November 7, 2024, at 11:00 AM and discontinued on November 7, 2024, shortly thereafter. Lorazepam 0.5 mg PO every 8 hours PRN for GAD for 30 Days then re-evaluate, ordered on November 26, 2024, and discontinued on December 12, 2024. Lorazepam 0.5 mg PO every 8 hours PRN for GAD for 90 Days, ordered on December 12, 2024, and currently active. Review of facility documentation revealed that staff initiated and re-ordered Resident 65's Ativan PRN	F 0758		

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F 0758 SS=E	Continued from page 51 medication on October 7, 2024. There was no documentation available that indicated Resident 65's physician, physician's assistant, or physician's assistant specializing in psychiatry saw them on October 7, 2024, to provide justification for the PRN Ativan. Review of Resident 65' behavior monitoring from August to December 2024, and January 2025, revealed staff documented behavior(s) on the following dates: August 23, 2024, evening shift August 27, 2024, day shift August 28, 2024, day and evening shifts August 31, 2024, day shift September 1, 4, 5, 10, 11, 21, 22, 28, and 29, 2024, day shift September 2, 14, 15, and 18, 2024, evening shift September 23, 2024, night shift October 7, 8. 13, 14, 15, 18, 20, 23, 25, and 26,	F 0758		

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F 0758 SS=E	Continued from page 52 2024, day shift October 19, 20, and 29, 2024, evening shift November 1, 3, 8, 10, 12, 13, 14, 18, 20, 21, 22, 26, 28, 2024, day shift November 16, 20, and 23, 2024, evening shift November 7 and 26, 2024, night shift December 3, 8, 10, 16, 19, 21, 22, 24, 28, 2024, day shift December 4, 7, 9, 11, 12, 13, 15, 19, 22, 26, 27, and 31, 2024, evening shift December 16 and 29, 2024, night shift January 2, 3, 4, 5, 6, 9, 10, 13, 14, 21, 2025, day shift January 4, 6, 7, 12, 13, 15, 16, 18, and 19, 2025, evening shift January 23, 2025, night shift Review of Resident 65's clinical record revealed that the facility's contracted physician's assistant specializing in psychiatry saw them on July 16 and	F 0758		

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F 0758 SS=E	Continued from page 53 25, 2024, August 6, 22, and 27, 2024, September 5, 12, and 19, 2024, October 17 and 29, 2024, November 12, 2024, December 10, 2024, and January 2, and 23, 2025. Further review of Resident 65' clinical record revealed that the facility's physician or physician's assistant saw them on August 23 and 26, 2024, September 10, 12, 25, and 27, 2024, October 17, 2024, November 3 and 24, 2024, December 2, 9, 19, 20, 24, and 29, 2024, and January 2, 5, and 19, 2025. On January 13, 2025, the consultant pharmacist reviewed Resident 65's medications and recommended to "evaluate if the PRN Ativan can be discontinued or if a 14 day stop date can be added." The facility's physician and contracted physician's assistant specializing in psychiatry responded "other" and "PRN Ativan has a 90 day stop date due to ongoing anxiety ...will continue to evaluate in the future." There was no other documentation available, which indicated Resident 65 had behavior(s) or that they	F 0758		

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F 0758 SS=E	Continued from page 54 were unable to be seen by a provider to justify and/or necessitate the need for extension of Resident 65's PRN Ativan medication longer than 14 days per regulatory compliance. Review of Resident 65's August through December 2024, and January 2025's, MAR (medication administration record, a form to document medication administration) revealed that the facility administered Ativan 0.5 mg PRN on the following dates: August 31, 2024, at 5:38 PM September 1, 2024, at 10:02 AM September 2, 2024, at 8:30 PM September 11, 2024, at 9:32 AM September 20, 2024, at 9:06 AM September 21, 2024, at 9:00 AM September 22, 2024, at 8:38 AM September 28, 2024, at 9:03 AM September 29, 2024, at 10:19 AM	F 0758		

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	395396	A. BLDG: 00 B. WING:	01/24/2025

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F 0758 SS=E	Continued from page 55 October 7, 2024, at 11:15 AM October 8, 2024, at 9:24 AM October 10, 2024, at 12:50 PM October 13, 2024, at 9:45 AM October 14, 2024, at 9:20 AM October 15, 2024, at 1:39 PM October 18, 2024, at 7:24 AM October 19, 2024, at 7:20 AM October 20, 2024, at 10:12 AM October 22, 2024, at 9:02 AM October 23, 2024, at 1:39 AM, 11:40 AM, and 8:03 PM October 28, 2024, at 7:49 AM and 8:31 PM October 30, 2024, at 8:51 PM November 1, 2024, at 12:00 PM November 2, 2024, at 7:43 AM November 3, 2024, at 10:48 AM November 5, 2024, at 8:30 AM November 8, 2024, at 5:00 PM November 10, 2024, at 8:15 AM November 13, 2024, at 8:42 AM November 14, 2024, at 8:14 AM	F 0758		

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F 0758 SS=E	Continued from page 56 November 15, 2024, at 2:36 PM November 16, 2024, at 9:05 AM November 17, 2024, at 1:54 PM November 20, 2024, at 8:05 AM and 3:57 PM November 21, 2024, at 8:36 AM December 1, 2024, at 8:20 AM December 3, 2024, at 9:13 AM December 7, 2024, at 4:00 PM December 8, 2024, at 3:11 AM December 9, 2024, at 3:20 AM and 3:19 PM December 10, 2024, at 8:28 AM December 11, 2024, at 2:51 AM December 13, 2024, at 1:18 PM December 14, 2024, at 7:42 AM December 16, 2024, at 4:00 PM December 19, 2024, at 8:51 AM December 20, 2024, at 5:02 PM December 21, 2024, at 4:21 PM December 24, 2024, at 6:28 PM December 26, 2024, at 4:11 PM December 28, 2024, at 7:20 AM December 29, 2024, at 12:42 AM and 8:46 AM	F 0758		

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F 0758 SS=E	Continued from page 57 There was no documentation that indicated non-medicinal interventions were attempted prior to administering the PRN Ativan medications. The surveyor reviewed this information during an interview with the Nursing Home Administrator and Director of Nursing on January 23, 2025, at 12:25 PM. 483.45(d)(e)(1)-(2) Drug Regimen is Free from Unnecessary Drugs Previously cited deficiency 2/16/24 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services	F 0758		
F 0761 SS=D		F 0761		

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F 0761 SS=D	Continued from page 58 483.45(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	Cited: All solutions and cleansers were removed from the window sill of resident 56.  Like: Facility-wide sweep will be completed to ensure treatment supplies/biologicals are not stored on the window sill in residents' rooms.  Educations: DON/designee will educate staff to ensure treatment supplies/biologicals are not stored on the window sill in residents' rooms.  Audits: DON/designee will audit 5 resident rooms weekly x 4 weeks then monthly x2 months to ensure treatment supplies/biologicals are not stored on the window sill in residents' rooms. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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 0761 SS=D	Continued from page 59 Based on observation and staff interview, it was determined that the facility failed to secure treatments on one of four nursing hallways (North Hall, Resident 56). Findings include: Observations of Resident 56's room on January 21, 2025, at 10:02 AM, January 22, 2025, at 10:19 AM, and January 23, 2025, at 10:52 AM, revealed two open bottles of Dakin's solution (an antiseptic used to treat and prevent infections in wounds), and a bottle of Derma wound cleanser (antiseptic for skin and wounds) on the windowsill. The label on the bottle read to keep out of reach of children, and if swallowed to get medical help, or call poison control. The above findings for Residents 56 and were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on January 23, 2025, at 2:29 PM. The Director of Nursing confirmed the above-mentioned items should not be	F 0761		

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	395396	A. BLDG: __00_____ B. WING: _____	01/24/2025

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F 0761 SS=D	Continued from page 60 stored on Resident 56's windowsill. 483.45(g)(h)(1)(2) Label/store Drugs and Biologicals Previously cited deficiency 2/16/24 28 Pa. Code 211.9 (a)(1)(k) Pharmacy services 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0761		
F 0812 SS=F		F 0812		

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 0812 SS=F	Continued from page 61 483.60(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	Cited: Bulk containers and soiled potholders were removed from service, with the contents of the containers discarded. Shelves in the steamer and prep areas were immediately cleaned, along with the floor and pipes in the steamer area. Cooler shelves were replaced, ceiling tiles were changed, and vents were thoroughly cleaned. Additionally, the plate warmer underwent a deep cleaning. Although the temperature logs for the food on the trayline for the cited dates could not be completed, the cook received proper education, and logs for future meals were successfully recorded. Like: Potholders and cooler shelves will be inspected to ensure they remain in good condition. Items that are worn or soiled will be replaced proactively. The structured cleaning schedule was revised for the steamer area, prep areas, floors (including pipe), vents, and plate warmer. Staff will be assigned specific cleaning tasks with checklists. The food service director/designee will review the	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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 0812 SS=F	Continued from page 62	F 0812	checklists to verify compliance. Cooks and staff will receive ongoing training on the importance of maintaining accurate temperature logs. The food service director/designee will review logs daily to ensure they are completed correctly. Educations: Food Safety and Sanitation training will be completed with all kitchen staff including the importance of maintaining cleanliness in food preparation areas with focus on proper cleaning and sanitizing procedures for kitchen equipment, shelves, and floors. Additionall y, staff will be educated on the importance of maintaining accurate temperature logs for food safety compliance, proper techniques for measuring and recording food temperatures, and how to troubleshoot and respond to temperature irregularities. Audits: Food Service Director/designee will complete a daily audit to ensure temperatures, bulk container labeling and dating,	

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F 0812 SS=F	Continued from page 63	F 0812	and cleaning tasks for floors (including pipe area) and shelves are completed. The daily audit will also include visual inspection for the cleanliness of potholders, ceiling tiles, and vents. Daily audits will be completed x 21 days, and will then be completed weekly.	

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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0812 SS=F	Continued from page 64 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service equipment in accordance with professional standards for food service safety in the facility's main kitchen. Findings include: Observation of the facility's main kitchen on January 21, 2025, at 8:58 AM with Employee 1, dietary director, revealed the following: Two large bulk clear plastic containers were observed on a lower shelf of a production table with a white substance in each container. One container was labeled as "flour" and the other "sugar," but there was no date to indicate when the products were placed in the containers or when they needed used by. Several white potholders were observed sitting on top of the convection oven. The potholders were soiled with dried foods and significantly stained.	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395396	A. BLDG: __00_____ B. WING: _____	01/24/2025

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F 0812 SS=F	Continued from page 65 The bottom shelf of the steamer and prep table had dried food debris. The bottom shelf of the steamer and lower shelf of the production table across from the steamer contained dust and dried food debris. The flooring under and behind the steamer and the table beside the steamer contained dried food and debris buildup. The area surrounding a pipe where it enters the floor behind the steamer was caked up with dried food and debris. A two-door cooler behind the serving line contained multiple shelves in the unit with exposed rust colored metal where the protective coating of the shelves had worn off. The exterior of the ceiling vents over the wall of coolers, the vents over the single door food cooler above the serving line, and the vents at the exit door of the kitchen to the resident hallway were covered	F 0812		

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F 0812 SS=F	Continued from page 66 in dust. The ceiling tile and light covers surrounding the vent over the single door cooler by the serving line were also covered in dust. Another ceiling tile over the single door cooler was significantly brown stained and drooping around a hole where an electrical cord came down through the tile to the single door cooler by the serving line. The plate warming unit contained dried food splatter on the exterior sides of the unit and the lower corner bumpers contained debris and dust. Observation of the food serving temperature log for January 21, 2025, revealed no temperatures were recorded for the items served at the breakfast meal that day as Employee 1 indicated breakfast had already been served to residents. There was no evidence that temperatures were checked for the food served. The temperature log also did not have temperatures recorded for breakfast January 20, 2025; the day prior.	F 0812		

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F 0812 SS=F	Continued from page 67 A follow up observation in the main kitchen on January 23, 2025, at 11:45 AM revealed four potholders sitting on top of the convection oven. The potholders were blackened and covered in dried food. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on January 23, 2025, at 2:30 PM. 483.60(i)(2) Store, prepare, food safe and sanitary Previously cited 2/16/24 28 Pa. Code 201.14 (a) Responsibility of Licensee	F 0812		
F 0880 SS=E		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=E	Continued from page 68 483.80(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	Cited: Employee's #8 was required to completed a medication administration pass competency with the DON.. Employee #9 was required to complete a treatment completion competency and was provided education relating to adherence to Enhanced Barrier Precautions .  Like: Licensed staff will complete a medication administrator competency directly related to infection prevention with medication preparation as well as following enhanced barrier precautions, and general infection control practices with dressing changes.  Education: DON/designee will educate nursing staff to ensure medication administration follows infection control procedures as well as following enhanced barrier precautions, and general infection prevention practices with	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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=E	Continued from page 69 (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	dressing changes.  Audits: Infection Preventionist/designee will audit 4 residents weekly then monthly x2 months to ensure medication administration follows infection control guidelines. Results will be taken through QAPI.	

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EDENBROOK SOUTH STATE LICENSE NUMBER: **641502**	**101 LEADER DRIVE** **WILLIAMSPORT, PA 17701**

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F 0880 SS=E	Continued from page 70	F 0880		

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F 0880 SS=E	Continued from page 71 Based on observation and staff interview, it was determined that the facility failed to prevent the potential spread of infection during medication administration pass for two of five residents observed (Residents 10 and 60), during a dressing change for one of one resident observed for a dressing change (Resident 50), and failed to adhere to enhanced barrier precautions for one of one resident observed during observation of a dressing change (Resident 50). Findings include: Observation of Employee 8 (Licensed Practical Nurse, LPN) during a medication administration pass on January 23, 2025, at 8:35 AM revealed she prepared the following medications for Resident 10, Famotidine (a medication used to treat ulcers of reflux disease) 20 milligrams (mg) two capsules; Mucinex (a medication used to treat cough caused by the common cold) 600 mg one tablet; One daily with minerals (a multi vitamin) one tablet; Vitamin D3 (used to supplement vitamin D in the body)	F 0880		

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F 0880 SS=E	Continued from page 72 1000 units, one capsule; Colace (a medication used to treat or prevent constipation) 100 mg one capsule; and Fexofenadine (a medication used to treat seasonal allergies) 180 mg one tablet, by taking them out of the bottle with her ungloved (bare) hand and placing them into the medication cup. Observation also revealed she punched out of a punch card the medication Clopidogrel (a medication used to prevent blood clots) that landed on top of her medication cart. She then picked up the pill with her ungloved hand and placed it into the medication cup. She entered Resident 10's room and administered the medications to her. Observation of Employee 8, LPN, during a medication administration pass on January 23, 2025, at 8:25 AM revealed she prepared the following medication for Resident 60, Famotidine 20 mg one capsule, by taking it from the bottle with her ungloved hand and placing it into the medication cup. She then entered Resident 60's room and administered the medication to her.	F 0880		

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F 0880 SS=E	Continued from page 73 Concurrent interview with Employee 8, confirmed the above noted findings. The Nursing Home Administrator and Director of Nursing were made aware of the concerns with medication administration pass on January 23, 2025, at 2:55 PM. Observation of Employee 9 , Registered Nurse, infection preventionist, and wound nurse, on January 24, 2025, at 10:30 AM during a dressing change of Resident 50's left lateral heel pressure ulcer, revealed she entered the room with her supplies and place them on Resident 50's overbed table. She did not clean or prepare the overbed table first, failing to establish a clean field for her supplies. She then sanitized her hands and donned gloves. She raised Resident 50's bed, removed her gloves, sanitized her hands, and put on a new pair of gloves. Without changing her gloves, Employee 9 then completed the following actions: took off Resident 50's non-skid sock, removed the old dressing, (Employee 9 should have donned new gloves) cleansed the area	F 0880		

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F 0880 SS=E	Continued from page 74 with normal saline solution and gauze, applied betadine to the area, covered it with a new dressing, reapplied residents' non-skid socks, discarded the old dressing, cleaned up her supplies, removed gloves, and washed her hands. Observation of the door to Resident 50's room revealed no sign indicating he was on enhanced barrier precautions (EBPs, precautions used to prevent the spread of multi-drug resistant organisms). Concurrent interview with Employee 9 revealed that EBPs should have been used when doing the dressing change to include a gown in addition to the gloves she wore. She also indicated that she should have set up a clean surface for her dressing supplies and changed her gloves after removing the old dressing from Resident 50's left heel. The Nursing Home Administrator and the Director of Nursing were made aware of concerns with Resident 50's dressing change concerns and concerns with enhanced barrier precautions on	F 0880		

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F 0880 SS=E	Continued from page 75 January 24, 2025, at 11:10 AM. 28 Pa. Code 201.18 (d) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services	F 0880		

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P 1700	Prevention, control and surveillance of tuber (b) Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB. This REGULATION is not met as evidenced by:	P 1700	Cited: Employees 2 and 3 will have a full TB screen completed.  Like: HRD/designee will complete a sweep of current staff members to ensure all staff have completed a TB screen.  Educations: NHA/designee will educate the HRD to ensure all staff have completed a TB screen upon hire.  Audits: HRD/designee will audit 5 staff members files weekly x4 weeks and monthly x 2 months to ensure all staff have completed a TB screen upon hire. Results will be taken through QAPI.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/06/2025**

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

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P 1700	Continued from page 1 Based on review of select personnel records and staff interview, it was determined that the facility failed to implement pre-employment screening procedures for tuberculosis (TB) for two of five newly hired employees reviewed (Employees 2 and 3). Findings include: The Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/tb-healthcare-settings/hcp/screening) last updated December 15, 2023, stipulates that all U.S. health care personnel should be screened for TB upon hire (i.e., preplacement) by either a TB blood test or a two-step TB skin test. Information from the baseline individual TB risk assessment should be used to interpret the results of a TB blood test or TB skin test given upon hire (i.e., preplacement). Health care personnel with a positive TB test result should receive a symptom evaluation and a chest x-ray to rule out TB disease. If a previous documented negative TB results in less	P 1700		

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P 1700	Continued from page 2 than 12 months before new employment is provided only a single test is required. Review of Employee 2's nurse aide (NA), personnel file revealed the facility hired the employee on November 14, 2024. Further review revealed the Employee 2 provided evidence of a negative TB skin test dated March 4, 2024, within 12 months of being hired at the facility. There was no evidence of any further testing (one-step, blood test, or chest x-ray) was completed upon Employee 2's employment at the facility. Review of Employee 3's, NA, personnel file revealed the facility hired the employee on December 10, 2024. Further review revealed the employee provided evidence of a prior negative TB blood test dated August 5, 2024, within 12 months of hire at the facility. There was no evidence Employee 3 received any further testing (one-step, blood test, or chest x-ray) prior to employment with the facility.	P 1700		

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P 1700	Continued from page 3 The Nursing Home Administrator confirmed the above findings in an interview on January 24, 2025, at 1:00 PM.	P 1700		
P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	Cited: Unable to correct staffing ratios for CNA's on the five days selected during the review.  Like: Staffing coordinator/designee will review the last two weeks to ensure staffing ratios are met. The facility is rolling out a new recruitment and retention plan under new ownership. This includes recruiting for regional recruiter, facility wage analysis, mentor program and employee retention initiatives.  Educations: NHA/designee will educate the staffing coordinator to ensure staffing ratios are met.  Audits: Staffing coordinator/designee will audit five random days weekly x 4 weeks then monthly x 2 months to ensure staffing ratios are met.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/07/2025**

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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P 5520	Continued from page 4 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents during the day shift for two of the 21 days reviewed and failed to ensure a minimum of one nurse aide per 15 residents during the overnight shift for three of the 21 days reviewed. Findings include: A review of nursing care hours provided by the facility dated from November 23, 2024, through November 29, 2024, December 26, 2024, through January 1, 2025, and January 17, 2025, through January 23, 2025, revealed the following: Day shift (requires one NA per 10 residents): December 29, 2024, census of 97 with 9.55 NAs, required 9.70 January 18, 2025, census of 101 with 8.50 NAs, required 10.10	P 5520		

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EDENBROOK SOUTH STATE LICENSE NUMBER: **641502**	**101 LEADER DRIVE WILLIAMSPORT, PA 17701**

(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
P 5520	Continued from page 5 Night shift (requires one NA per 15 residents): January 1, 2025, census of 96 with 4.85 NAs, required 6.10 January 19, 2025, census of 103 with 6.10 NAs, required 6.87 January 21, 2025, census of 102 with 4.47 NAs, required 6.80 Interview with the Nursing Home Administrator on January 23, 2025, at 2:27 PM confirmed that the facility did not meet regulatory NA-to- resident ratios as evidenced above.	P 5520		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395396	A. BLDG: __00_____ B. WING: _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
EDENBROOK SOUTH STATE LICENSE NUMBER: **641502**	**101 LEADER DRIVE WILLIAMSPORT, PA 17701**

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P 5640	Continued from page 6 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	Cited: Unable to correct the staffing PPD for the three days reviewed. - Like: Staffing coordinator/designee will review the last two weeks to ensure staffing PPD are met. The facility is rolling out a new recruitment and retention plan under new ownership. This includes recruiting for regional recruiter, facility wage analysis, mentor program and employee retention initiatives. - Educations: NHA/designee will educate the staffing coordinator to ensure staffing PPD are met. - Audits: Staffing coordinator/designee will audit five random days weekly x 4 weeks then monthly x 2 months to ensure staffing PPD is met.	Completion Date: **03/12/2025** Status: **APPROVED** Date: **02/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395396	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
EDENBROOK SOUTH STATE LICENSE NUMBER: **641502**	**101 LEADER DRIVE** **WILLIAMSPORT, PA 17701**

(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
P 5640	Continued from page 7 Based on review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure the total of nursing care hours provided in each 24-hour period was a minimum of 3.2 hours per patient day (PPD), effective July 1, 2024, for three of the 21 days reviewed. Findings include: Review of nursing staff care hours for November 23, 2024, through November 29, 2024, December 26, 2024, through January 1, 2025, and January 17, 2025, through January 23, 2025, revealed that the facility failed to meet the minimum hours per patient day for the following days: January 1, 2025, 3.05 January 18, 2025, 3.07 January 19, 2025, 3.14 Interview with the Nursing Home Administrator on January 23, 2025, at 2:27 PM confirmed that the facility did not meet regulatory daily hours PPD as evidenced above.	P 5640		

Certified End Page

EDENBROOK SOUTH

STATE LICENSE NUMBER: 641502

SURVEY EXIT DATE: 01/24/2025

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
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