STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: 00 B. WING:	02/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHURCH OF GOD HOME INC STATE LICENSE NUMBER: **291602**	**801 NORTH HANOVER STREET** **CARLISLE, PA 17013**

(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 February 6, 2025, it was determined that Church of God Home 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.	F 0000		
F 0623 SS=E		F 0623		

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 0623 SS=E	Continued from page 1 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1. Unable to retroactively correct the clinical record for Residents 1, 28, 52, 53, and 58 with a notice upon transfer that included required and revised information. All residents continue to reside at the facility. R69 no longer resides at the facility, no adverse effects related to practice. 2. All residents have the potential to be impacted. R1, R28, R52, R53 and R58 will be given the revised Transfer or Discharge form with the appropriate notice of information no later than March 14, 2025 for any immediate Transfer or Discharge, along with a facility wide audit conducted by the DON and Shift Supervisors. 3. DON will educate the Shift Supervisors by March 14, 2025 upon emergent transfer to the hospital and will provide the revised Notice of Resident Transfer or Discharge form to resident and document in a progress note via the EHR system (PCC) to reflect it was presented with appropriate information. The Shift	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/25/2025**

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F 0623 SS=E	Continued from page 2 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623	Supervisor is to then complete a progress note documenting the notice was provided and to whom. The DON will also educate Shift supervisor on the updated Notice of Resident Transfer on Discharge form, and to provide the Notice of Resident Transfer to Discharge Form to the Resident revealing the mailing address of the entity, which receives request for appeals, mailing address of the Office of the State Long Term Care Ombudsman for protection and advocacy of individuals with developmental disabilities and mental disorders. The DON will in-service the Shift Supervisors by March 14, 2025 to ensure the representative is provided the notice and signed the form when received. DON will also educate the Social Worker by March 14, 2025 to send a 30-day log of transfer and discharges to the local Ombudsman's' email box. 4. Social Worker Director and DON will conduct a record audit via the progress notes of all residents	

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F 0623 SS=E	Continued from page 3 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by:	F 0623	who have emergent transfer to the hospital and audit the transfer and discharge log to be sent to the Ombudsman daily x 3 to ensure the Notice of Residents Transfer or Discharge information contained appropriate information and was given and signed appropriately, to whom until 100% completion is achieved. Audits will continue x2 weekly, until 100% is achieved. Findings of the audits will be reported monthly to the QAPI committee meeting to ensure compliance is obtained and maintained.	

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F 0623 SS=E	Continued from page 4 Based on clinical record review and staff interviews, it was determined that the facility failed to provide a notice of transfer for two of six residents reviewed for hospitalization (Residents 28 and 53), and failed to provide five of six residents reviewed for transfers with a notice of transfer that included the required information (Residents 1, 28, 52, 58, and 69). Findings include: Review of Resident 1's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and hyperlipidemia (high fat levels in the blood). Review of Resident 1's clinical record revealed that on January 1, 2025, Resident 1 was transferred to the hospital due to an acute medical change in condition.	F 0623		

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F 0623 SS=E	Continued from page 5 Review of facility document, "Notice of Resident Transfer or Discharge," provided to Resident 1's Representative, revealed the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 6, 2025, at 11:35 AM, the NHA confirmed that the required mailing addresses were not present on the facility transfer notices. Review of Resident 28's clinical record revealed diagnoses that included heart failure, chronic kidney disease, and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes,	F 0623		

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F 0623 SS=E	Continued from page 6 and impaired reasoning). Review of Resident 28's clinical record revealed that the Resident had been transferred and admitted to the hospital on June 29, 2024; July 21 and 30, 2024; August 8, 2024; and October 18, 2024. Review of Resident 28's "Notice of Transfer or Discharge" forms signed by their Representative for their June 29, 2024; July 21 and 30, 2024; and October 18, 2024, hospital transfers revealed that the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. Further review of Resident 28's clinical record revealed that a "Notice of Transfer or Discharge"	F 0623		

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F 0623 SS=E	Continued from page 7 was not present for the August 8, 2024 hospital transfer. During a staff interview with Employee 9 on February 4, 2025, at 12:52 PM, Employee 9 indicated that they had called Resident 28's Representative about their August 8, 2024, transfer but failed to get the paperwork signed by Resident 28's Representative. During an interview on February 5, 2025, at 1:10 PM, the NHA confirmed that Resident 28's Representative should have been provided the notice and that they should have signed the form when received. During a staff interview on February 6, 2025, at 11:30 AM, the NHA confirmed that the required mailing addresses were not present on the facility transfer notices. Review of Resident 52's clinical record, revealed diagnoses that included hypertension (elevated/high	F 0623		

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F 0623 SS=E	Continued from page 8 blood pressure). Review of Resident 52's clinical record revealed that on September 14, 2024, Resident 52 was transferred to the hospital due to an acute medical change in condition. Review of facility document, "Notice of Resident Transfer or Discharge," provided to Resident 52's Representative, revealed the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. Review of Resident 53's clinical record, revealed diagnoses that included dementia (irreversible, progressive degenerative brain disease that results in decreased contact with reality and decreased ability	F 0623		

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F 0623 SS=E	Continued from page 9 to perform activities of daily living) and hypertension. Review of Resident 53's clinical record revealed that Resident 53 was sent to the hospital for evaluation after Resident 53 suffered a fall at the facility on May 21, 2024. Review of available clinical records revealed no evidence that Resident 53 nor Resident 53's Representative was provided a notice of transfer for the transfer to the hospital on May 21, 2024. During a staff interview on February 6, 2025, at approximately 11:00 AM, DON confirmed that the facility did not have documentation that Resident 53, nor Resident 53's Representative was provided with a transfer notice. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that	F 0623		

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F 0623 SS=E	Continued from page 10 prevents urine from draining properly). Review of Resident 58's clinical record revealed that the Resident had been transferred and admitted to the hospital on October 17, 2024. Review of Resident 58's "Notice of Transfer or Discharge" form signed by their Representative for their October 17, 2024, hospital transfer revealed that the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. Review of Resident 69's clinical record on February 5, 2025, revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the	F 0623		

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F 0623 SS=E	Continued from page 11 blood stream into the cells for nourishment) and hypertension. Review of Resident 69's clinical record revealed that on November 12, 2024, Resident 69 was transferred to a hospital due to an acute medical change in condition. Review of facility document, "Notice of Resident Transfer or Discharge," provided to Resident 69's representative, revealed the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. During a staff interview with the NHA and DON on February 6, 2025, at 11:30 AM, the NHA confirmed that the required mailing addresses were	F 0623		

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F 0623 SS=E	Continued from page 12 not present on the facility transfer notices. 28 Pa. Code 201.14(a) Responsibility of licensee	F 0623		
F 0625 SS=E		F 0625		

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F 0625 SS=E	Continued from page 13 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625	1. Unable to retroactively correct the clinical record for R28 and R53 to provide clinical record of the facility's bed-hold notice upon date of transfer or discharge from the facility. Both residents continue to reside at the facility. Unable to retroactively correct the clinical record for R1, R28, R52, R58 and R69 to provide bed-hold notices that included the required information upon transfer, residents continue to reside at the facility. R69 no longer resides at the facility, no adverse effects related to practice. 2. All residents have the potential to be impacted. R1, 28, 52, 53, and 58 immediately will be given the form regarding Bed Hold Notice regulation no later than March 14, 2025 or any need for bed hold notice immediately of Transitions of Care Policy and Procedure, Admission, Transfers, and Discharge for the Resident and/or Resident Representative. R69 no longer resides at the facility, no adverse effects related to practice.	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/25/2025**

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F 0625 SS=E	Continued from page 14	F 0625	3. Facility wide Audits of all bed hold transfers or discharges for the past 3 months will be conducted by the DON and/or Shift Supervisor. Any residents who do not have the appropriate information on the bed transfer form will be given a new form with the revised information by March 14, 2025. 4. The DON will in-service the Shift Supervisor upon emergent transfer to the hospital to provide the Notice of Bed Hold form to the resident by March 14, 2025. The Shift Supervisor is to then complete a progress note stating it was provided, and to whom. DON will educate the Shift Supervisors on the revised Notice of Bed Hold Form to the resident upon emergent transfer to the hospital, and document in a progress note in the EHR (PCC) System that it was given. 4. Social Worker Director and DON will conduct a record audit via the progress notes of all residents who	

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F 0625 SS=E	Continued from page 15	F 0625	have emergent bed-hold notices upon transfer or discharge to the hospital and audit the transfer and discharge log to be sent to the Ombudsman daily x 3 to ensure the Notice of Residents Transfer or Discharge form was given and signed appropriately, to whom until 100% completion is achieved. Audits will continue x2 weekly, until 100% is achieved. Findings of the audits will be reported monthly to the QAPI committee meeting to ensure compliance is obtained and maintained.	

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F 0625 SS=E	Continued from page 16 Based on clinical record review and staff interviews, it was determined that the facility failed to provide a copy of the facility's bed-hold notice upon transfer or discharge from the facility for two of six residents reviewed for transfer or discharge (Residents 28 and 53), and failed to provide bed-hold notices that included the required information for five of six residents reviewed for transfer or discharge (Residents 1, 28, 52, 58, and 69). Findings include: Review of Resident 1's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and hyperlipidemia (high fat levels in the blood). Review of Resident 1's clinical record revealed that the Resident had been transferred and admitted to the hospital on January 1, 2025.	F 0625		

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F 0625 SS=E	Continued from page 17 Review of Resident 1's "Bed Hold Prior to Transfer" forms signed by their Representative for their January 1, 2025, hospital transfer revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 5, 2025, at 1:10 PM, the NHA confirmed that the duration of the state bed-hold and bed-reserve rate should have been included in the bed-hold notice. Review of Resident 28's clinical record revealed diagnoses that included heart failure, chronic kidney disease, and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 28's clinical record revealed that the Resident had been transferred and admitted to	F 0625		

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F 0625 SS=E	Continued from page 18 the hospital on June 29, 2024; July 21 and 30, 2024; August 8, 2024; and October 18, 2024. Review of Resident 28's "Bed Hold Prior to Transfer" forms signed by their Representative for their June 29, 2024; July 21 and 30, 2024; and October 18, 2024, hospital transfers revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. Further review of Resident 28's clinical failed to reveal that a "Bed Hold Prior Transfer or Discharge" or was present for their August 8, 2024, hospital transfer. During a staff interview with Employee 9 on February 4, 2025, at 12:52 PM, Employee 9 indicated that they had called Resident 28's Representative about their August 8, 2024, transfer but failed to get the paperwork signed by Resident 28's Representative.	F 0625		

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F 0625 SS=E	Continued from page 19 During a staff interview with the NHA and DON on February 5, 2025, at 1:10 PM, the NHA confirmed that Resident 28's Representative should have been provided the facility bed-hold policy at the time of each hospital transfer and the duration of the state bed-hold and bed-reserve rate should have been included in the bed-hold notice. During a staff interview with the NHA and DON on February 6, 2025, at 11:30 AM, the NHA confirmed that the required mailing addresses were not present on the facility transfer notices. Review of Resident 52's clinical record on February 3, 2025, revealed diagnoses which included hypertension (elevated/high blood pressure) and diabetes mellitus type two (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). Review of Resident 52's clinical record revealed that on September 14, 2024, Resident 52 was	F 0625		

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F 0625 SS=E	Continued from page 20 transferred to the hospital due to an acute medical change in condition. Review of the facility bed-hold notice, provided and signed by Resident 52's Representative on September 16, 2024, revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. Review of Resident 53's clinical record on February 4, 2025, revealed diagnoses which included dementia and hypertension. Review of Resident 53's clinical record revealed that Resident 53 was sent to the hospital for evaluation after Resident 53 suffered a fall at the facility on May 21, 2024. Review of available clinical records failed to revealed documentation that Resident 53, or Resident 53's representative, received a copy of the Facility's bed-hold policy upon transfer to the	F 0625		

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F 0625 SS=E	Continued from page 21 hospital on May 21, 2024. During a staff interview on February 6, 2025, at approximately 11:00 AM, DON confirmed that the facility did not have documentation that Resident 53, nor Resident 53's Representative was provided with the facility's bed-hold policy upon transfer on May 21, 2024. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that prevents urine from draining properly). Review of Resident 58's clinical record revealed that the Resident had been transferred and admitted to the hospital on October 17, 2024. Review of Resident 58's "Bed Hold Prior to Transfer" form signed by their Representative for their October 17, 2024, hospital transfer revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the	F 0625		

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F 0625 SS=E	Continued from page 22 reserve bed payment, if any. Review of Resident 69's clinical record on February 5, 2025, revealed diagnoses which included type two diabetes mellitus and hypertension. Review of Resident 69's clinical record revealed that on November 12, 2024, Resident 69 was transferred to a hospital due to an acute medical change in condition. Review of the facility bed-hold notice, provided and signed by Resident 69's representative on November 12, 2024, revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. During a staff interview with the NHA and DON on February 5, 2025, at 1:10 PM, the NHA confirmed that the duration of the state bed-hold and bed-reserve rate should have been included in the bed-hold notice.	F 0625		

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F 0625 SS=E	Continued from page 23 28 Pa. Code 201.14(a) Responsibility of licensee	F 0625		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 24 483.20(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. R17 quarterly MDS was corrected to reflect weight loss, R28 Medicare 5 Day MDS was corrected to reflect weight loss and R58 quarterly MDS was corrected to reflect urinary catheter. All residents reside at the facility. No adverse effects related to practice. 2. All residents have the potential to be impacted. The MDS Coordinator will conduct a facility audit of the most recent completed MDS assessments for all residents to identify correct cording of weight/loss/gain: and correct coding of indwelling catheter by March 14, 2025. Any coding errors identified in the audit will be corrected as well. 3. DON and/or NHA to educate the MDS Coordinator by March 14, 2025 on Section K, Swallowing and Nutritional Status of the RAI Manual; and Section H Bowel and Bladder of the RAI Manual that includes the importance of thoroughly reviewing the medical record prior to completing the MDS	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/25/2025**

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F 0641 SS=D	Continued from page 25	F 0641	Assessment. 4. Audits to be completed by the MDS Coordinator for the MDS section K and Section H on 5 residents weekly x4 then monthly for 2 months, until 100% is achieved. Findings of the audits will be reported monthly to the QAPI committee meeting to ensure compliance is obtained and maintained.	

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F 0641 SS=D	Continued from page 26 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 30 residents reviewed (Residents 17, 28, and 58). Findings include: Review of Resident 17's clinical record revealed diagnoses that included vascular dementia (a type of dementia caused by brain damage from impaired blood flow marked by memory disorders, personality changes, and impaired reasoning), dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 17's clinical record revealed he had a significant weight loss of 31 pounds (-11.5%) from May 10, 2024, to November 4, 2024. Review of Resident 17's Quarterly MDS (Minimum	F 0641		

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F 0641 SS=D	Continued from page 27 Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of November 19, 2024, revealed in Section K. Swallowing and Nutritional Status, the question weight loss of more than 5% in the last month or loss of 10% or more in the last 6 months, was marked "no or unknown." Email correspondence with the Nursing Home Administrator (NHA) on February 4, 2025, at 4:08 PM, revealed the MDS should have been marked for weight loss and was being modified by the RNAC (Registered Nurse Assessment Coordinator). During a follow-up interview with the NHA on February 6, 2025, at 2:33 PM, she confirmed that she would expect a resident's MDS to be coded accurately. Review of Resident 28's clinical record revealed	F 0641		

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F 0641 SS=D	Continued from page 28 diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 28's clinical record revealed a nutrition/dietary note dated October 28, 2024, at 12:04 PM, that indicated a comprehensive nutrition assessment had been completed as Resident 28 had returned from a hospital stay. The note indicated that Resident 28 had experienced a significant weight gain over 30 days, 3 months, and 6 months. In addition, there was a late entry nutrition/dietary note dated October 28, 2024, at 3:28 PM, that indicated Resident 28 had experienced a significant weight loss following hospitalization, not a significant gain as previously documented. Review of Resident 28's Medicare 5 Day MDS	F 0641		

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F 0641 SS=D	Continued from page 29 with the assessment reference date of November 1, 2024, revealed in Section K. Swallowing and Nutritional Status that did not have a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. During a staff interview with the NHA, Director of Nursing (DON), and Employee 2 (Dietician) on February 6, 2025, from 2:10 PM, to 2:25 PM, Employee 2 confirmed that Resident 28's MDS was coded inaccurately regarding their weight loss. The NHA confirmed that she would expect a resident's MDS to be coded accurately. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that prevents urine from draining properly). Review of Resident 58's physician orders revealed an order for an indwelling Foley catheter dated October 22, 2024.	F 0641		

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F 0641 SS=D	Continued from page 30 Review of Resident 58's October 2024 and November 2024 Treatment Administration Records revealed that Resident 58 had a foley catheter in place. Review of Resident 58's Quarterly MDS with the assessment reference date November 8, 2024, revealed in Section H. Bowel and Bladder that they were not coded as having a urinary catheter. Email communication received from the NHA on February 5, 2025, at 8:33 AM, confirmed that Resident 58's foley catheter was not coded correctly on their Quarterly assessment dated November 8, 2024, and indicated that the Registered Nurse Assessment Coordinator would complete a modification. During a staff interview with the NHA and DON on February 6, 2025, at 11:20 AM, the NHA confirmed that she would expect that she would expect a resident's MDS to be coded accurately.	F 0641		

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F 0641 SS=D	Continued from page 31 28 Pa Code 211.12 (d)(3)(5) Nursing services	F 0641		
F 0657 SS=E		F 0657		

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F 0657 SS=E	Continued from page 32 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1. R4 unable to retroactively correct care plan. R4 was recently offered to participate in the care planning process and declined on 2/19/25 invited by the Activities Director, documented on clinical record of resident's choice to decline. R4 acknowledged understanding of residents right to participate in the care planning process. R28 unable to retroactively correct clinical record of the presence of the rash, it is confirmed the rash was resolved. R28 care plan was reviewed and updated to reflect all care areas specific to the resident preferences, such as wearing a bra daily. Section V of the MDS care area assessment summary for R28 was also updated for assistance with eating, oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, transfers, and mobility, along with preference of importance to choose clothing. R28's care plan specifics for ADL self-care performance also reviewed	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: 00 B. WING:	02/06/2025

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F 0657 SS=E	Continued from page 33	F 0657	for additional interventions and updated. R37 care plan for rash was updated on 2/6/25 for the treatment of the rash. R58 care plan was updated on 2/17/25 to reflect the antipsychotic medication was being utilized to manage residents identified targeted behaviors and on 2/5/25 it was indicated on the R58's care plan that it was updated to reflect antipsychotic use. R4, R28, R37 and R58 currently reside at the facility and no adverse effects related to practice. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. The DON, Shift Supervisors, Social Services, Activities Director and MDS Coordinator will audit all care plans to ensure the comprehensive care plans are being updated or new care plans completed for all residents including readmissions from hospital to reflect individual preferences and Resident-specific ADL information to include interventions by March 14, 2025.	

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F 0657 SS=E	Continued from page 34	F 0657	3. To prevent other residents from being affected the DON will re-educate the Social Services and Activities Director, Activities Director and Shift Nurse Supervisors by March 14, 2025 on the requirements and policy of the Comprehensive Care Plan and quarterly review assessments, as well as compliance with the Care Plan Revisions. Additional, training to include residents right to be invited to Comprehensive Care plans and document that the invite was offered or refused, along with documentation that resident understands and acknowledges their rights to attend care plan meetings. The DON will also educate on directives of physician orders, documenting the identification of any medical concerns or progress along with interventions and treatment follow up for residents. The DON and NHA will also in-service the IDT Team on communication of any new information or updates in the daily	

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F 0657 SS=E	Continued from page 35	F 0657	standup and clinical meetings to include, change of condition or significant change to be updated in the resident's care plan. 4. An audit will be conducted by the DON, Activities and/or Social Services Director to ensure comprehensive care plans and assessments are completed timely, updated/revised for all residents weekly x 4 then monthly for 2 months, until 100% is achieved. Findings of the audits will be reported monthly to the QAPI committee meeting to ensure compliance is obtained and maintained.	

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F 0657 SS=E	Continued from page 36 Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the residents right to participate in the care planning process for one of 18 resident's reviewed (Resident 4), and the facility failed to review and revise the resident plan of care for three of 18 residents reviewed (Residents 28, 37, and 58). Findings include: Review of facility policy, titled "Comprehensive Care Plans" with a last revised date of October 23, 2022, and a last review date of January 17, 2025, revealed, in part, "3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment."	F 0657		

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F 0657 SS=E	Continued from page 37 Review of facility policy, titled Care Plan Revisions Upon Status Change, with a last revised date of April 18, 2023, and a last review date of January 17, 2025, revealed, in part, "The Comprehensive Care Plan will be reviewed, and revised as necessary, when a resident experiences a status change; the MDS Coordinator and Interdisciplinary Team will discuss the resident condition and collaborate on intervention options; the team meeting will be documented in the progress notes; and the care plan will be updated with the new or modified interventions." Review of facility policy, titled "Care Planning-Resident Participation", last revised April 18, 2023, read, in part, "Policy: This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). The facility will honor the resident's choice in individuals to be included in the care planning process. The facility will honor requests for care plan meetings and acknowledge requests for revisions to the person-centered plan of	F 0657		

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F 0657 SS=E	Continued from page 38 care. The facility will discuss the plan of care with the resident and/or resident representative at regularly scheduled care plan conferences." Review of Resident 4's clinical record revealed she was admitted to the facility on October 3, 2024, with diagnoses that included dysphagia (difficulty swallowing), hypertension (high blood pressure), and overactive bladder (a bladder control problem which leads to a sudden urge to urinate). Interview with Resident 4 on February 4, 2025, at 1:13 PM, revealed she has not been invited to a care plan meeting. Review of Resident 4's clinical record revealed three multidisciplinary care conference notes dated November 5, 18, and 22, 2024; further review of the care conference notes failed to reveal Resident 4 attended the meetings. Email correspondence with the Nursing Home Administrator (NHA) on February 5, 2025, at	F 0657		

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F 0657 SS=E	Continued from page 39 11:49 AM, revealed it is her expectation that residents are invited to their care plan meetings. She further revealed there is a new activities director that has taken a lead on coordinating care plan meetings, and they need to make sure she knows to document attendance in the notes and whether residents declined or attended. During a follow-up interview with the NHA on February 6, 2025, at 11:36 AM, she revealed the documentation that Resident 4 was invited to her care plan was missed. Review of Resident 28's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning).	F 0657		

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F 0657 SS=E	Continued from page 40 During an interview with Resident 28 on February 3, 2025, at 10:12 AM, she indicated that she has a rash that itches, which has been going on for about 6 months and that the staff applies a cream to the rash. Review of Resident 28's clinical record revealed that the Resident was identified as having a skin rash on November 22, 2024. Review of Resident 28's physician orders revealed orders for a dermatology consult dated November 22, 2024; Sarna External Lotion 0.5-0.5 % (Camphor &Menthol) apply to rash topically two times a day for rash/itchiness, dated November 22, 2024; anti-fungal powder (house stock) every morning and at bedtime for fungal areas to groin and under breasts, dated December 2, 2024; and hydroxyzine HCl (hydrochloride) oral tablet 25 mg (milligrams) Give 1 tablet by mouth at bedtime for itch, dated December 19, 2024. Review of Resident 28's care plan failed to reveal any documentation of the presence of any rash or	F 0657		

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F 0657 SS=E	Continued from page 41 their interventions for the treatment of the rash. During a staff interview with the NHA and Director of Nursing (DON) on February 6, 2025, at 11:26 AM, the DON confirmed that she would expect the rash to have been on Resident 28's care plan. During the same interview with Resident 28 on February 3, 2025, at 10:17 AM, she indicated that she would like to wear a bra every day. Resident 28 reported that she was not wearing one. During a follow-up interview with Resident 28 on February 4, 2025, at 11:43 AM, she again indicated that she was not wearing a bra. She said she did not know if it was because she did not have one. Review of Resident 28's Significant Change MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of August 21, 2024, revealed in	F 0657		

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F 0657 SS=E	Continued from page 42 Section F. Preferences for Routine & Activities that it was somewhat important to her to be able to choose her clothing. Review of Resident 28's Significant Change MDS with the with the assessment reference date of August 21, 2024, revealed in Section V. Care Area Assessment Summary that they needed assistance with eating, oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, transfers, and mobility. The summary also indicated that these areas would be care planned. Review of Resident 28's care plan revealed a care plan focus for personalized care general. Interventions included keep phone in reach at all times, dated November 5, 2024; and may go out on therapeutic leave with medication, dated October 29, 2024. Further review of Resident 28's care plan revealed a	F 0657		

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F 0657 SS=E	Continued from page 43 care plan focus for ADL (activities of daily living) self-care performance deficit related to activity intolerance and limited mobility. The only intervention was "Transfer: full mechanical lift with 2 assist", dated September 27, 2024. During an interview with Employee 9 on February 4, 2025, at 12:50 PM, they indicated that they had searched Resident 28's room and found 3 bras. Employee 9 further indicated that staff had put a bra on the Resident. Email communication received from the NHA on February 5, 2025, at 8:33 PM, indicated that it was determined that when Resident 28 was discharged to the hospital in August, her care plan was closed and then, upon return, a new care plan needed completed. She indicated that preferences were not completed upon that re-admission because they were not required on that assessment and, therefore, no preferences were pulled to their care plan. The NHA indicated that this concern was missed during facility care plan reviews and that a preference form	F 0657		

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F 0657 SS=E	Continued from page 44 will be completed and care plan updated accordingly. In an email communication received from the NHA on February 6, 2025, at 1:29 PM, she confirmed that when Resident 28's next MDS was completed on November 6, 2024, their care plan should have been reviewed and someone should have identified that Resident 28's care plan was missing Resident-specific ADL information. Review of Resident 37's clinical record revealed diagnoses that included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body), chronic kidney disease, and dementia. Observation of Resident 37 on February 3, 2025, at 11:48 AM, revealed the presence of a raised red rash across their chest and bilateral arm. Resident 37 was observed to be scratching their left arm.	F 0657		

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F 0657 SS=E	Continued from page 45 Review of Resident 37's clinical record revealed that were identified as having a skin rash on November 26, 2024. Review of Resident 37's physician orders revealed orders for Sarna External Lotion 0.5-0.5 % (Camphor &Menthol) Apply to bilateral legs and groin topically every day and evening shift for rash, dated November 26, 2024; and an order for hydroxyzine HCl Oral Tablet 25 mg Give 1 tablet by mouth at bedtime for itchiness/rash, dated February 4, 2025. Review of Resident 37's progress notes revealed a note dated February 3, 2025, at 10:27 PM, that indicated, in part, "Resident continues with rash to entire body. Resident reports feeling itchy and noted taking clothes off to scratch ...Sarna itch lotion applied. Resident stated it helped her not feel itchy." Review of Resident 37's care plan failed to reveal any documentation of the presence of any rash or	F 0657		

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F 0657 SS=E	Continued from page 46 their interventions for the treatment of the rash. During a staff interview with the NHA and DON on February 6, 2025, at 11:26 AM, the DON confirmed that Resident 37's rash should have been included on their care plan. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that prevents urine from draining properly). Review of Resident 58's physician orders revealed an order for quetiapine (Seroquel) [an antipsychotic medication] 25 mg tablet give 12.5 mg by mouth at bedtime for dementia, dated October 22, 2024. Review of Resident 58's Significant Change MDS with the with the assessment reference date of October 29, 2024, revealed in Section V. Care Area Assessment Summary that the Resident received an antipsychotic medication daily. The	F 0657		

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F 0657 SS=E	Continued from page 47 summary also indicated that these areas would be care planned. Review of Resident 58's Quarterly MDS with the with the assessment reference date of November 8, 2024, revealed in Section N. Medications that the Resident was still receiving an antipsychotic medication daily. Review of Resident 58's care plan failed to reveal any documentation of their antipsychotic medication use or their identified target behaviors the antipsychotic medication was being utilized to manage. Email communication received from NHA on February 5, 2025, at 8:33 PM, indicated that Resident 58's care plan was updated to reflect antipsychotic use. During a staff interview with the NHA and DON on February 6, 2025, at 11:20 AM, the DON confirmed that Resident 58's care plan should have	F 0657		

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F 0657 SS=E	Continued from page 48 included their antipsychotic medication use as well as their identified target behaviors. 42 CFR 483.21(b) Comprehensive Care Plans 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services	F 0657		
F 0686 SS=D		F 0686		

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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 0686 SS=D	Continued from page 49 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. R2 no longer resides at the facility. The DON educated E3 immediately on Initiation of Enhanced Barrier Precautions to be obtained for residents with chronic wounds such as pressure ulcers consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, this includes all residents under any type of precautions to ensure appropriate signage is posted to reflect as such. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. A facility wide audit will be conducted by the DON and or IP Nurse and nursing staff by March 14, 2025 to identify residents under any type of precautions to ensure appropriate signage is posted prior to employees entering the room. 3. DON and IP Nurse will educate all staff by March 14, 2025 addressing observance of signs	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: __00_____ B. WING: _____	02/06/2025

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F 0686 SS=D	Continued from page 50	F 0686	posted on the door to determine PPE precautions and the use of gloves, mask, gown when performing high contact procedures and to ensure gowns and gloves available immediately near or outside of the resident's room. 4. Random Audits will be conducted by IP Nurse and or DON of at least five residents per week for 4 weeks then monthly for 2 months until 100% compliance is achieved or as otherwise determined by Risk Management Team/Quality Assurance Committee to ensure compliance is obtained and maintained.	

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F 0686 SS=D	Continued from page 51 Based on observation, policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services to promote healing and prevent infection in accordance with professional standards for one of two residents reviewed for pressure ulcers (Resident 2). Findings include: Review of facility policy, titled "Enhanced Barrier Precautions," last reviewed January 17, 2025, revealed the facility's policy stated, "It is the policy of the this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms." Review of the aforementioned policy revealed section "2. Initiation of Enhanced Barrier Precautions," subsection "b" stated, "An order for enhanced barrier precautions will be obtained for residents with any of the following ...Wounds (e.g., chronic wounds such as pressure ulcers ...even if the resident is not known to be infected or colonized	F 0686		

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F 0686 SS=D	Continued from page 52 with a [multi-drug resistant organism." Section 3, "Implementation of Enhanced Barrier Precautions," subsection "a" stated, "Make gowns and gloves available immediately near or outside of the resident's room ..." Further, review of subsection 9 Droplet Precautions, revealed it included, "f. Based upon the pathogen or clinical syndrome, if there is risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn." Review of Resident 2's clinical record on February 4, 2025, revealed diagnoses that included dementia (progressive, irreversible degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure). Review of Resident 2's clinical record revealed	F 0686		

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F 0686 SS=D	Continued from page 53 Resident 2 had an unstageable pressure injury (wound of the skin that has an undetermined depth due to the wound bed being covered with dead tissue or other wound debris) of the third toe on the right foot. Prior to wound treatment observation on February 5, 2025, at approximately 12:45 PM, Employee 3 (Licensed Practical Nurse) stated that Resident 2 had been diagnosed with influenza. Prior to entering Resident 2's room for wound treatment observation on February 5, 2025, at approximately 12:50 PM, the door to Resident 2's room was observed to have a sign that stated the room was on droplet precautions, which required the use of a facemask and gloves. Upon entering Resident 2's room, it was observed that a sign indicating enhanced barrier precautions (use of gloves, mask, gown when performing high contact procedures such as wound treatment) was attached the back of Resident 2's door.	F 0686		

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F 0686 SS=D	Continued from page 54 Employee 3 was observed entering the Resident room with a facemask and was observed performing hand hygiene and glove changes while performing the wound treatment to Resident 2's toe; however, Employee 3 did not place a gown on during the wound treatment, per Enhanced Barrier Precautions. During a staff interview after the wound treatment, Employee 3 was asked about the Enhanced Barrier Precaution sign. Employee 3 stated that Resident 2 was placed on droplet precautions for influenza and was no longer on Enhanced Barrier Precautions, which is why the sign for Enhanced Barrier Precautions was on the back of Resident 2's door. During a staff interview on February 5, 2025, at approximately 1:30 PM, Director of Nursing (DON) revealed that Resident 2 would still be considered under the Enhanced Barrier Precaution protocol while also under droplet precautions. During the staff interview, DON confirmed that possible coughing by Resident 2 could present	F 0686		

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F 0686 SS=D	Continued from page 55 possible exposure to respiratory secretions for those in the room. DON revealed that Employee 3 should have worn a gown while performing the treatment to Resident 2's pressure ulcer per the Enhanced Barrier Precaution requirements. 28 Pa code 211.12(d)(1)(5) Nursing services	F 0686		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 56 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. R35 resides at the facility and R47 no longer resides at the facility, both residents have the potential to be impacted by the deficient practice. The IDT team met and reviewed R35 fall care plan to ensure it reflects appropriate interventions that is appropriate for residents' clinical diagnosis that includes dementia (a brain disorder that causes a decline in cognitive function, memory, and behavior, sever enough to interfere with daily life). 2. Current residents will have their fall risk assessment reviewed and residents identified at risk will have a care plan update to ensure appropriate interventions are in place. Including conducting a fall mat audit by the DON and Facilities Director to ensure care plans match fall mat policy and resident care needs and positioning of the mat, if deemed necessary to prevent future occurrence by March 14, 2025. 3. A fall packet will be placed on	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0689 SS=D	Continued from page 57	F 0689	the nursing units that will include a list of possible interventions to initiate post fall. DON and IDT Team will be re-educating staff on February 26, 2025 on the implementation of interventions immediately post fall and observance of residents who may not be in compliance with call bell protocol or lack awareness of usage to review and guide the team to the appropriate interventions. All falls will be reviewed in the clinical daily meeting with the IDT team to ensure an appropriate intervention has been added to the resident's care plan. 4. Falls that occurred will be reviewed by the DON and clinical team weekly x 4 weeks then monthly x 3 months to ensure appropriate interventions are initiated, added to the care plan and in place, along with auditing of the use of mats for the individual resident. This plan of correction will be monitored at the monthly Quality Assurance meeting until consistent substantial compliance has been met.	

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F 0689 SS=D	Continued from page 58 Based on record review, observation, and staff interviews, it was determined that the facility failed to prevent accident and hazards for two of 18 residents reviewed (Residents 35 and 47.) Findings include: Review of Resident 35's clinical record revealed diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and, eventually, the ability to carry out the simplest tasks) and hyperlipidemia (high levels of fats in the bloodstream). Review of Resident 35's fall incident report that occurred on September 8, 2024, revealed Resident 35 had an un-witnessed fall that occurred in the Resident's bathroom. The Incident Description revealed, in part, "This writer was called to residents' room related to unwitnessed fall in bathroom. Walker noted to foot of bed in residents' room. Bathroom call bell was not activated. Staff reports assisting resident to the bathroom and	F 0689		

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F 0689 SS=D	Continued from page 59 providing her with the call bell prior to fall. No staff member present in the bathroom when resident attempted to get herself off the toilet. No apparent injuries noted." Review of Resident 35's comprehensive care plan revealed an Activities of Daily Living (ADL) focus area with an intervention for toilet use: assist of one, with an initiation date of June 13, 2024; and an intervention for transfer: one assist with rolling walker and gait belt, with an initiation date of June 13, 2024. During an interview with Employee 3 on February 5, 2025, at 12:09 PM, revealed Resident 35 was not able to use her call bell and does not ever use it. During an interview with Employee 4 on February 5, 2025, at 9:57 AM, revealed Resident 35 did not understand how to use their call bell, and will often yell out instead when the Resident needed assistance.	F 0689		

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F 0689 SS=D	Continued from page 60 During an interview with Employee 5 on February 5, 2025, at 9:43 AM, revealed Resident 35 did not understand how to use their call bell. Review of Resident 35's clinical record reveals the Resident has a BIMS (brief interview for mental status) score of 3, which suggest severe cognitive impairment. During an interview with the Nursing Home Administrator (NHA) on February 5, 2025, revealed that Resident 35 should not have been left alone in the bathroom during the fall incident that occurred on September 8, 2024, and that the staff member involved was terminated. NHA revealed they determine if a resident is able to use a call bell based off of their BIMS in most circumstances. Review of Resident 47's clinical record revealed diagnoses that included dementia (a brain disorder that causes a decline in cognitive function, memory, and behavior, severe enough to interfere with daily life) and hypertension (high blood pressure).	F 0689		

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F 0689 SS=D	Continued from page 61 Observation on February 3, 2025, on 1:04 PM, revealed Resident 47 was not in their room, although there was a fall mat on the floor to the left side of their bed. Review of Resident 47's comprehensive care plan revealed a focus area for being a fall risk with an intervention for their fall mat to left side of bed when Resident in bed. Remove when out of bed, with an initiation date on April 8, 2024. Review of Resident 47's clinical record revealed an incident note on December 17, 2024, that read, in part, "A staff member responded to an unwitnessed fall in Resident 47's room. Arrived to Resident 47 sitting on the left side of her bed leaning up against her bed with grip socks on and fall mat not in place. No injuries were found. Staff educated on placing fall mat." During an interview with the NHA on February 5, 2025, at 8:32 PM, revealed education was	F 0689		

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F 0689 SS=D	Continued from page 62 provided in ensuring Resident 47's fall mat is properly in place. 28 Pa. Code 201.18(b)(1)(2)Management 28 Pa. Code 211.12(d)(3)(5)Nursing services	F 0689		
F 0692 SS=G		F 0692		

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F 0692 SS=G	Continued from page 63 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. R17 corrected with new order in an effort to advance diet texture, along with double portions of protein with each meal, R28 and R58 missing weight and documentation was corrected and MD notification was made aware of current weight along with dietician, all residents continue to reside at the facility. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. The DON and/or Dieticians will conduct an order review by March 14, 2025 to identify any residents that have orders for daily weights perimeters to notify the MD with weight changes to also ensure they are appropriately calculated based on weight and medical diagnosis and following the dietitian comprehensive nutrition assessment. Facility wide audit will be conducted by the dietician and DON for any resident identified with missing documentation, missing MD notification and physician orders not	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0692 SS=G	Continued from page 64	F 0692	followed up on by March 14, 2025. 3. DON will educate the Dietitian to fill out a communication form upon a significant weight gain over 30 days, 3 months, and 6 months to be given to the DON and placed in the MDs review folder. In the daily standup meetings, the dietitian notes will be reviewed for significant weight loss/gain with the IDT team to ensure communication and MD notification is implemented and documented timely in the Treatment Administration Record. The DON will also educate the Rehab Department on documenting refusals as evidenced in speech therapy to ensure consult or supplements were discussed with the physician and documented in the EHR (PCC) by March 14, 2025. The DON and Dietician will educate all nursing staff and the IDT team on the policy and procedure of nutrition and hydration status maintenance of the clinical process of fluid and dietary status per individual resident to monitor fluctuations that would be	

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F 0692 SS=G	Continued from page 65	F 0692	anticipated and may trigger significant weight loss/ gain by March 14, 2025. 4. An audit of all residents will be conducted to ensure weights are being completed according to physician orders, therapy refusals are be conducted, and ensuring documentation is completed weekly x 4 then monthly x 2 by the DON and /or Dietitian to ensure the resident has no signs of significant weight loss, until 100% compliance is achieved. The findings of the audits will be reported at the monthly and quarterly QAPI meeting until consistent compliance has been met.	

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F 0692 SS=G	Continued from page 66 Based on facility policy review, clinical record review, and staff and resident representative interviews, it was determined that the facility failed to ensure proper monitoring to maintain acceptable parameters of nutritional status for three of six residents reviewed for nutrition or hydration (Residents 17, 28, and 58). This failure resulted in harm for Resident 17, as evidenced by significant weight loss. Findings include: Review of facility policy, titled "Weight Monitoring," last reviewed January 17, 2025, read, in part, "The facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates this is not possible or residents preferences indicate otherwise ...the facility will utilize a systematic approach to optimize a residents nutritional status. This process includes ...Monitoring the effectiveness of interventions and	F 0692		

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F 0692 SS=G	Continued from page 67 revising them as necessary ...Residents with weight loss-monitor weight weekly ...the physician should be informed of a significant change in weight and may order nutritional interventions ...The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes ...the interdisciplinary plan of care communicates care instructions to staff." Review of Resident 17's clinical record revealed diagnoses that included vascular dementia (a type of dementia caused by brain damage from impaired blood flow marked by memory disorders, personality changes, and impaired reasoning), dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 17's clinical record revealed he had oral surgery on May 20, 2024, with recommendation to follow a soft diet for a week after surgery.	F 0692		

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F 0692 SS=G	Continued from page 68 Review of Resident 17's physician orders revealed a diet order, "Regular diet, Mechanical Soft texture, Regular/Thin consistency, Soft diet is recommended for first week post extractions", with a start date of May 20, 2024, and discontinued May 27, 2024. Review of Resident 17's physician orders revealed a diet order, "Regular diet, Regular texture, Regular/Thin consistency, mechanical soft meats; add gravy to meats", with a start date of May 28, 2024, and discontinued on June 16, 2024. Review of Resident 17's physician orders revealed a change to the diet order on June 16, 2024, "Regular diet, Puree texture, Regular/Thin consistency." Review of Resident 17's clinical record revealed a progress note on June 16, 2024, that stated "Resident was in dining room at lunch and resident was observed coughing on corn. Resident was able to clear the corn. Resident also noted to be coughing on mechanical soft ground ham. Spoke	F 0692		

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F 0692 SS=G	Continued from page 69 with resident and resident is ok with puree foods. Spoke with POA (power of attorney- legal representative) who was unaware that resident went back to Regular diet mechanical soft meats. POA is ok with resident being pureed. Dietary made aware." Review of Resident 17's clinical record revealed a significant weight loss of 28 pounds (-10.4%) from April 23, 2024, to October 18, 2024. Review of Resident 17's clinical record revealed a dietitian note on October 25, 2024, that read, in part, "Review of monthly weight. Current weight of 241.8 pounds (October 18, 2024) triggers as a significant loss in 6 months. Weight fluctuations anticipated related to diuretic therapy. Recommending weekly weights to monitor trend. Resident continues to tolerate a regular diet, puree, thin liquids. Weight loss and intake reviewed with POA; POA is not interested in supplementation at this time. POA sees weight loss as beneficial. Care plan reviewed/updated."	F 0692		

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F 0692 SS=G	Continued from page 70 A follow up dietitian note was linked to the aforementioned note on October 29, 2024, that read, "Per nursing, resident with decreased snacking between meals; may contribute to weight loss." Review of Resident 17's physician orders on February 5, 2025, revealed that the diuretic was not a new medication for him, and he had been on it since March 1, 2023. Review of Resident 17's physician orders revealed an order to "Weigh weekly every day shift every Monday", with a start date of October 28, 2024. Review of Resident 17's clinical record failed to reveal weekly weights were obtained on the week of November 11 and 18, 2024. During an email correspondence with the Nursing Home Administrator (NHA) on February 5, 2025, at 11:49 AM, the surveyor inquired if the aforementioned weekly weights were obtained, she	F 0692		

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F 0692 SS=G	Continued from page 71 revealed, "These weights were not obtained. On November 11, 2024, the PRN [as needed] nurse who was working didn't sign off with no explanation. On November 18, 2024, the agency nurse signed off saying it would be obtained on 3-11 shift, but the weight was then missed by 3-11." Additionally, during the email correspondence with the NHA on February 5, 2025, at 11:49 AM, she revealed "[Physician notification of] weight loss missing on [Resident 17] due to communication between dietitian and POA stating she felt the weight loss was ok due to his current weight. Therefore, no notification was made to the physician. We had lots of conversation at interdisciplinary meetings around this as [Resident 17] had recently had oral surgery and was not snacking as prior. He also had been downgraded to puree diet and he was not happy with his meal options. All weight loss (anticipated and not) is discussed at QAPI (quality assurance meeting) monthly. [Resident 17's] weight loss situation did not follow normal protocol due to circumstances	F 0692		

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F 0692 SS=G	Continued from page 72 explained." In an additional interview with the NHA on February 5, 2025, at 1:39 PM, she stated that residents with weight loss are discussed in QAPI, and the physician signs the QAPI sign in sheet. No physician notification or response to the weight loss was noted in Resident 17's medical record. Review of Resident 17's weight measures revealed his weight loss continued 8.8 pounds (-3.6%) from October 18, 2024, to December 2, 2024. Review of Resident 17's clinical record revealed a dietitian note on December 4, 2024, that read, in part, "Weight and intake reviewed with [POA]; she maintains wish for no supplementation at this time." Further review of Resident 17's weight measures revealed his weight loss continued 8.2 pounds (-3.5%) from December 2, 2024, to January 20, 2025.	F 0692		

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F 0692 SS=G	Continued from page 73 Review of Resident 17's clinical record revealed a physician note written by Employee 6 (Medical Director) on January 30, 2025, that read, "Resident weight noted down some, intake good, on Lasix [diuretic medication] monitor [electro]lytes, NAD, today eating lunch." Interview with Employee 2 (Registered Dietitian) on February 5, 2025, at 1:35 PM, revealed she was concerned about Resident 17's weight loss, but the Resident's POA did not want him on supplements. During an interview with the NHA and the Director of Nursing (DON) on February 5, 2025, at 1:39 PM, revealed the weekly weights that were missed should have been obtained per physician order, and that Resident 17 has remained on a puree diet because his POA refused speech therapy services for a potential diet upgrade. The surveyor requested documentation in the medical record to indicate the refusal of speech therapy services and any physician involvement in response to weight loss prior to January 30, 2025.	F 0692		

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F 0692 SS=G	Continued from page 74 Interview with Resident 17's POA on February 6, 2025, at 2:58 PM, revealed she did not refuse speech therapy services and that, when supplements were discussed with her, she was concerned that Resident 17 needs more food rather than supplements, and he would eat more food if he wasn't on a puree diet. Follow-up interview with the NHA and DON on February 6, 2025, at 3:38 PM, the surveyor revealed the concern with lack of documentation to indicate speech therapy services were refused and lack of physician response to the significant weight loss, no further information was provided. The Resident was noted to have significant weight loss. The Resident was not reassessed by speech therapy after his diet was downgraded in June 2024. There was no evidence that a speech therapy consult or supplements were discussed with the physician. There were no physician progress notes that addressed Resident 17's weight loss from when	F 0692		

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F 0692 SS=G	Continued from page 75 his weight loss became significant in September 2024, until January 30, 2025. Review of Resident 28's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 28's physician orders revealed an order for "Daily weight - Notify MD if increase of 3 pounds in 24 hr or gain/loss of 5 pounds in 1 week every night shift for fluid balance management", with an original order date of October 26, 2024. Review of Resident 28's Treatment Administration Record for October revealed that on October 28, 2024, the weight and signature box were both	F 0692		

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F 0692 SS=G	Continued from page 76 blank; October 30, 2024, was signed as completed on night shift but the box where the weight was to be entered was marked with an "X" and the entries for the weight and signature boxes on day shift were blank; and October 31, 2024, was signed as completed on night shift with an "X" marked in the box where the weight was to be entered. Review of additional information provided by the facility revealed that Resident 28 weighed 144 pounds on October 30, 2024, and weighed 152.3 pounds on October 31, 2024, indicating an 8.3-pound weight gain in 24 hours. Review of Resident 28's progress notes failed to reveal any documentation that their physician was notified of the greater than 3-pound weight gain in 24 hours on October 31, 2024. Review of Resident 28's Treatment Administration Record for November 2024 revealed that the Resident refused their weight on November 15 and 24, 2024. All other entries for the month were	F 0692		

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F 0692 SS=G	Continued from page 77 signed that the weight was obtained, but the box where the weight was to be entered was marked with an "X." Review of Resident 28's Treatment Administration Record for December 2024 revealed that on December 10 and 11, 2024, the weight and signature box were both blank; December 1-9, and 12-20, 2024, were signed that the weight was obtained, but the box where the weight was to be entered was marked with an "X." Further review of Resident 28's Treatment Administration Record for December 2024 revealed that on December 24, 2024, the Resident weighed 146.8 pounds and on December 25, 2024, weighed 150 pounds; indicating a 3.2-pound weight gain in 24 hours. In addition, on December 28, 2024, the Resident weighed 153.5 pounds and on December 29, 2024, weighed 156.8 pounds; indicating a 3.3-pound weight gain in 24 hours. Review of Resident 28's progress notes failed to	F 0692		

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	395784	A. BLDG: 00 B. WING:	02/06/2025

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F 0692 SS=G	Continued from page 78 reveal any documentation that their physician was notified of the greater than 3-pound weight gain in 24 hours on December 25 or 29, 2024. Review of Resident 28's Treatment Administration Record for January 2025 revealed that the Resident refused their weight on January 11, 13, 16, 17, and 24, 2025; and on January 1 and 19, 2025, the weight and signature boxes were both blank. Further review of Resident 28's Treatment Administration Record for January 2025 revealed that on January 29, 2025, the Resident weighed 150.8 pounds and on January 30, 2025, weighed 157 pounds; indicating a 6.2-pound weight gain in 24 hours. Review of Resident 28's progress notes failed to reveal any documentation that their physician was notified of the greater than 3-pound weight gain in 24 hours on January 30, 2025. Review of Resident 28's Treatment Administration	F 0692		

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	395784	A. BLDG: __00_____ B. WING: _____	02/06/2025

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F 0692 SS=G	Continued from page 79 Record for February revealed that on February 1 and 4, 2025, the weight and signature boxes were both blank. Further review of Resident 28's clinical record revealed a nutrition/dietary note dated October 28, 2024, at 12:04 PM, that indicated a comprehensive nutrition assessment had been completed when Resident 28 returned from a hospital stay. The note indicated that Resident 28 had experienced a significant weight gain over 30 days, 3 months, and 6 months. There was a late entry nutrition/dietary note dated October 28, 2024, at 3:28 PM, that indicated Resident 28 had experienced a significant weight loss following hospitalization, not a significant gain as previously documented. Review of Resident 28's progress notes revealed a physician's progress note dated October 29, 2024, at 4:27 PM, which indicated that Resident 28 was seen post hospital stay and the vital signs and	F 0692		

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F 0692 SS=G	Continued from page 80 appetite were "ok" and that the Resident had minimal edema (swelling) to their bilateral legs. There was no documentation of an assessment of Resident 28's significant weight loss. Email communication received from the NHA on February 5, 2025, at 8:33 PM, indicated that she acknowledged Resident 28 had missing weights. During an interview with the NHA, DON, and Employee 2 (Dietician) on February 6, 2025, at 11:53 AM, Employee 2 confirmed that Resident 28 had a significant weight loss upon return to the facility from a hospital stay. Employee 2 indicated that the weight loss was reviewed with Resident 28's physician during the Quality Assurance Performance Improvement (QAPI) Meeting on November 15, 2024. The DON confirmed that she would expect staff to obtain and document resident weights as ordered and that staff should have notified Resident 28's physician of the greater than 3-pound weight gains as per physician order.	F 0692		

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F 0692 SS=G	Continued from page 81 Email communication received from the NHA on February 6, 2025, at 1:29 PM, confirmed that Resident 28's October 28, 2024, weight loss was reviewed in the facility's QAPI Meeting on November 15, 2024, at which Resident 28's physician was in attendance. She confirmed that she had no information to provide that the physician assessed Resident 28 for their weight loss. In addition, the NHA confirmed that she would expect that Resident 28's daily weights to be obtained, documented, and physician follow-up completed as indicated in the order. During a staff interview with the NHA and the DON on February 6, 2025, at 2:10 PM, the NHA acknowledged that the Resident 28's physician was not made aware of their weight loss identified on October 28, 2024, until November 15, 2024. During a final staff interview with the NHA, DON, and Employee 2 on February 6, 2025, 2:25 PM, the DON indicated that she could not give a direct expectation of physician notification of a weight loss	F 0692		

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F 0692 SS=G	Continued from page 82 because it is on a "case-by-case basis." She said that she felt Resident 28's physician was aware that she had been hospitalized in October and that he would have been aware of treatment received at the hospital regarding her fluid status and the continued monitoring at the facility. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and dysphagia (difficulty swallowing). Review of Resident 58's progress notes revealed a weight change note dated August 1, 2024, at 3:56 PM, that indicated Resident 58's weekly weights were reviewed and that Resident 58 current weight triggered as a significant loss (7.1%) over 30 days. The note also indicated that the weight fluctuations would be anticipated related to diuretic therapy. Review of Resident 58's progress notes revealed a nutrition/dietary note dated August 16, 2024, at 10:06 AM, that indicated that Resident 58's weekly weights were reviewed and that Resident 58's	F 0692		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHURCH OF GOD HOME INC STATE LICENSE NUMBER: 291602	801 NORTH HANOVER STREET CARLISLE, PA 17013

(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 0692 SS=G	Continued from page 83 weight was "fairly stable" over approximately a 3-week span, but the Resident continued to trigger for a significant loss over 30 days. Review of Resident 58's physician progress notes that were dated August 7, 11, 15, 16, 22, and 28, 2024, all of which failed to reveal any documentation of them being aware of or evaluating Resident 58's significant weight loss. Review of Resident 58's clinical record revealed a nutrition/dietary note dated October 24, 2024, at 3:00 PM, that indicated a comprehensive nutrition assessment was completed upon the Resident's return to the facility from a hospital stay, and Resident 58 was noted to have a significant loss over 30 and 180 days following hospitalization. The note further indicated that weekly weight monitoring was in place per admission protocol, that Resident 58's oral intake was not adequate to meet needs, and supplements were added. Review of Resident 58's physician progress notes	F 0692		

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F 0692 SS=G	Continued from page 84 revealed notes that were dated October 25, 28, 29, and 30, 2024, all of which failed to reveal any documentation of them being aware of or evaluating Resident 58's significant weight loss. Review of Resident 58's Treatment Administration Record for November 2024 revealed that on November 18, 2024, it was signed that the weight was obtained, but the box where the weight was to be entered was marked with an "X." Email communication from the NHA on February 5, 2025, at 8:33 PM, regarding Resident 58's identified weight losses on August 1 and 16, 2024, the "dietician documented that weight was stable and that weight loss was anticipated due to diuretic therapy" and "this would not be considered emergent and would be discussed at QAPI." The NHA further indicated that in November 2024 and December 2024 Resident 58's weight loss remained on the dietician's report and that there was still monitoring of the weight loss. She also indicated that Resident 58's weight loss was first discussed in	F 0692		

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F 0692 SS=G	Continued from page 85 August QAPI meeting reports, in which Resident 58's physician participated. During a staff interview with the NHA, DON, and Employee 2 on February 6, 2025, at 12:20 PM, the NHA confirmed that they could not provide any information for Resident 58's weight being signed as completed with no weight recorded on November 18, 2024. She said that she would expect weights to have been obtained as ordered by the physician. She again indicated that weight losses were reviewed with the physician during the facility's monthly QAPI meeting. She confirmed that there was no physician documentation regarding Resident 58's weight loss. During a final staff interview with the NHA, DON, and Employee 2 on February 6, 2025, at 2:25 PM, the DON indicated that she could not give a direct expectation of physician notification of weight loss because "it is on a case-by-case basis." 28 Pa Code 201.18(b)(1) Management	F 0692		

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F 0692 SS=G	Continued from page 86 28 Pa Code 211.2(d)(3) Medical director 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services	F 0692		
F 0758 SS=E		F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: 00 B. WING:	02/06/2025

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F 0758 SS=E	Continued from page 87 483.45(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	1. R53 potential side effects monitored for behaviors was corrected in the clinical record, care plan updated and resident continues to reside at the facility. R58's potential targeted behavior side effect is being monitored, corrected in the clinical record, care plan updated for behaviors and resident continues to reside at the facility. 2. The facility lacked evidence of side effect monitoring for the residents' individual psychotropic medications and monitoring of target behaviors for unnecessary psychotropic medications. The facility has determined that all residents prescribed psychotropic medication have the potential to be affected by this alleged deficient practice. DON is currently monitoring R53 and R58 prescribed psychotropic medication for side effects and targeted behaviors and will be conducting a facility wide audit by March 14, 2025 with the Shift Supervisors to review and ensure side effects and targeted	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0758 SS=E	Continued from page 88 §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	behaviors are in place and documented in the medical record for each individual resident. 3. DON will re-educate clinical management on monitoring possible side effects and target behaviors for all residents on psychotropic medication by March 14, 2025. Routine GDR meetings are currently being held monthly by the DON, NHA, shift supervisors, medical director, IDT staff members, and Pharmacy Consultant for review. 4. The NHA, DON and Medical Director will conduct 3 random audits of at least five residents receiving psychotropic medication to ensure side effects are monitored. The audit will be conducted once a week for 4 weeks then monthly for 2 months until substantial compliance is achieved or as otherwise determined by the findings reported at the monthly and quarterly QAPI meeting until consistent compliance has been met.	

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F 0758 SS=E	Continued from page 89 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to adequately monitor possible side effects and target behaviors for two of five residents reviewed for unnecessary psychotropic medications (Residents 53 and 58). Findings include: Review of facility policy, titled "Psychoactive Medication Policy," last reviewed January 17, 2025, revealed subsection "Psychoactive Medication Monitoring," stated, " 'Monitoring' is the ongoing collection and analysis of information and comparison to resident baseline in order to [sic] [a]scertain the resident's response to treatment and care, including progress or lack of progress toward therapeutic goal[;] [d]etect complications or adverse consequences of the condition or of the treatments[; and,] [s]upport decisions to modify, discontinue, or continue any interventions." Further review of the aforementioned policy	F 0758		

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F 0758 SS=E	Continued from page 90 revealed subsection, titled "Psychoactive Medication Monitoring Procedure," revealed it stated, "Behavior Management Flow Records (BMFR) will be utilize to record and monitor the number of mood/behavior events each shift, non-pharmacological interventions attempted, and observed adverse consequences..." Review of Resident 53's clinical record on February 4, 2025, revealed diagnoses that included dementia (irreversible, progressive degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure). Review of Resident 53's physician's orders revealed an order for Abilify (atypical antipsychotic medication used to treat mental health disorders) 2 mg (milligrams - metric unit of measure) once a day for the indication of hallucinations, which was most recently ordered on December 11, 2024. Review of Resident 53's care plan for the use of the atypical antipsychotic medication, with the focus of,	F 0758		

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F 0758 SS=E	Continued from page 91 "[Resident 53] uses psychotropic medications [related to] [diagnosis] hallucinations, revealed the intervention to monitor possible side effects, specific to the use of an atypical antipsychotic medication, which included ...unsteady gait, tardive dyskinesia [chronic, involuntary movement disorder that can occur with long-term us of antipsychotic medication], EPS [extrapyramidal symptoms] (shuffling gait, rigid muscles, shaking) ..." Review of Resident 53's monitoring for side effects of Abilify, documented by licensed nursing staff in Resident 53's Medication Administration Record (documentation tool utilize to record when medication, treatments, and/or other identified care and services ordered by the physician are completed), revealed the side effect monitoring for the Abilify medication was listed as an anti-depressant. Review of the specific symptoms monitored revealed that it did not include the side effects specific to antipsychotic medications as listed above	F 0758		

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F 0758 SS=E	Continued from page 92 and included in Resident 52' care plan. During a staff interview on February 6, 2025, at approximately 11:30 AM, Director of Nursing (DON) confirmed that the side effect monitoring for Resident 52's atypical antipsychotic medication did not include the side effects specific to antipsychotic medications. During the interview, it was confirmed that side effect monitoring for Resident 52 was changed to include the items identified in the care plan. Further, review of Resident 52's clinical record failed to reveal documented monitoring of Resident targeted behaviors and/or hallucinations. During the staff interview on February 6, 2025, DON confirmed that Resident 52 did not have behavior monitoring in place but that, it had been added as a result of the review. Review of Resident 58's clinical record revealed diagnoses that included dementia (a chronic disorder	F 0758		

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F 0758 SS=E	Continued from page 93 of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression. Review of Resident 58's physician orders revealed an order for quetiapine (Seroquel) [an antipsychotic medication] 25 mg tablet give 12.5 mg (milligrams) by mouth at bedtime for dementia, dated October 22, 2024; Ativan Oral Tablet 0.5 MG (lorazepam) Give 0.5 mg by mouth every 12 hours for Anxiety, dated October 22, 2024; and Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 60 mg by mouth one time a day for Depression, dated October 22, 2024. Review of Resident 58's clinical record revealed that nursing staff were monitoring for potential side effects of antipsychotic, antianxiety, and antidepressant medication use on their Medication Administration Records until October 18, 2024, at	F 0758		

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F 0758 SS=E	Continued from page 94 which time they were sent to the hospital for an acute illness. Further review of Resident 58's clinical record failed to reveal any documentation of what their actual identified target behaviors were, nor any monitoring of those target behaviors. Review of Resident 58's care plan failed to reveal any documentation of their antipsychotic medication use, potential side effects to monitor for, or their identified target behaviors for which the antipsychotic medication was being utilized to manage. During a staff interview with the Nursing Home Administrator (NHA) and DON on February 6, 2025, at 11:20 AM, the DON confirmed that Resident 58's care plan should have included their antipsychotic medication use, side effects to monitor for, as well as their identified target behaviors. She indicated that nurse aides document on the task documentation any behaviors that they observe. She	F 0758		

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F 0758 SS=E	Continued from page 95 further indicated that the facility expectation was that the Licensed Practical Nurse assigned to the Resident would write a progress note if a resident was exhibiting behaviors. She said the side effect monitoring was included in the Resident's orders until her hospitalization and, when she came back, it was not caught. DON confirmed that she would expect the side effect monitoring of Resident 58's antipsychotic, antianxiety, and antidepressant medications to have been included on their care plan and in their orders for documentation and monitoring purposes. She confirmed that she had no documentation to provide which would indicate Resident 58's identified target behaviors. Email communication received from the NHA on February 5, 2025, at 8:33 PM, indicated that Resident 58's care plan was updated to reflect their antipsychotic medication use and that their newly formed psych[iatric] review team had been working with pharmacy and geriatric psychiatry consultant, as well as the Medical Director, to ensure that gradual dose reductions, pharmacy	F 0758		

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F 0758 SS=E	Continued from page 96 recommendations, and regulations were followed. She further indicated that they would add to that meeting a review of a Resident's behavior monitoring tool in the task section of electronic health record with each Resident review. Email communication received from the NHA on February 6, 2025, at 12:53 PM, the NHA confirmed that she would expect Resident 58's care plan to have included their antipsychotic medication use and that Resident 58's identified target behaviors should have been identified and care planned. The NHA further indicated that it was not facility practice for nursing staff to document and track behaviors on a Resident's Medication or Treatment Administration Record. The NHA confirmed that Resident 58's antipsychotic, antianxiety, antidepressant side effect monitoring should have been on their Medication Administration Record for staff to complete on every shift. 28 pa code 211.12(d)(1)(3)(5) Nursing services	F 0758		

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 0790 SS=D		F 0790		

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F 0790 SS=D	Continued from page 98 483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) 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; §483.55(a)(4) 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 location; and §483.55(a)(5) Must promptly, within 3 days, refer residents	F 0790	1. R52 currently resides at the facility and has been added to the recommended identified contracted dental center for the resident's individual dental consult sheet of dental x-rays and surgical consult for extraction of teeth by March 14, 2025. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. Current residents will be reviewed by the DON and Shift Supervisors to ensure that routine dental services are provided when needed and by March 14, 2025. 3. Re-education will be provided by DON to the licensed nursing staff to include routine and emergency dental services per policy by March 14, 2025. 4. DON and Nurse Supervisors will conduct an audit of at least 5 random residents to determine if dental services have been received as necessary. These audits will be	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0790 SS=D	Continued from page 99 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. This REQUIREMENT is not met as evidenced by:	F 0790	done weekly x4 weeks and then monthly x2 until substantial compliance is achieved or as determined by the findings reported at the monthly and quarterly QAPI meeting until consistent compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395784	A. BLDG: 00 B. WING:	02/06/2025

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F 0790 SS=D	Continued from page 100 Based on clinical record review, resident and staff interviews, and facility document review, it was determined that the facility failed to ensure residents are assisted with obtaining routine dental care for one of one residents reviewed for dental care (Resident 52). Findings include: Review of Resident 52's clinical record on February 3, 2025, revealed diagnoses that included hypertension (elevated/high blood pressure) and diabetes mellitus type two (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). During a resident interview on February 3, 2025, Resident 52 indicated that he was awaiting teeth extraction of his upper teeth in order to have a full-upper denture created. During the interview, Resident 52 stated that he had a partial top denture that moves around as he eats.	F 0790		

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F 0790 SS=D	Continued from page 101 Review of Resident 52's clinical record revealed a dental consultation that was conducted on October 21, 2024. Review of the dental consultation sheet revealed that section "Treatment notes," stated, "[Patient] wears upper partial denture. [Patient] removed upper partial. Noted [patient] appears to have retained root tips under existing upper partial . recommend FMX [x-rays of the mouth] in order to evaluate dentition ...will follow up with [patient] following xrays ...[patient] will be set up for a oral surgery consult for extractions following xray review ..." Further, review of consult sheet's "Recommended treatment," section revealed the box for "Other X-Ray; FMX needed to evaluate dentition." Review of Resident 52's clinical record on February 5, 2025, revealed that, as of review, Resident 52 had not had any dental x-rays completed, nor had there been any consultation order for the extraction of Resident 52's upper teeth.	F 0790		

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F 0790 SS=D	Continued from page 102 Review of facility document, titled "Visit Summary," submitted on February 6, 2025, at 2:29 PM, revealed it was a document that listed the Resident's evaluated on October 21, 2025, along with recommendations and/or orders made by the dentist, and future treatment(s) recommended by the dentist. Review of the "Visit Summary," revealed Resident 52's "Recommendations / Orders," and "Future Treatment(s)," did not include the recommendation identified on Resident 52's individual dental consult sheet of dental x-rays and surgical consult for extraction of teeth. During a staff interview on February 6, 2025, at approximately 3:20 PM, Nursing Home Administrator revealed that the physician reviews the "Visit Summary" and would provide orders that were indicated on that sheet, and since the recommendations identified on Resident 52's individual dental consultation form were not included	F 0790		

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F 0790 SS=D	Continued from page 103 in the "Visit Summary" document, Resident 52 would not have had further treatment or consultation. 28 Pa code 211.12(d)(3)(5) Nursing services 28 Pa code 211.15 Dental services	F 0790		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 104 483.60(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. The dish machine temporary log and utilizing kitchen equipment has been corrected and the NHA educated (E8) Food Service Director and dietary staff immediately on the professional standards for food service safety in the main kitchen, including logging the dishwasher temperatures. 2. The facility has determined that all residents have the potential to be affected by this alleged deficient practice. No adverse effects related to the deficiency cited. 3. The Food Service Director (E8), Assisted Food Director and dietary staff were educated immediately by the NHA and will continued to be monitored by March 14, 2025 and observed by the NHA on utilizing professional standard kitchen equipment for food service safety and logging the dish machine temperature during all meal periods. 4. The Food Director and Assistant Director of Dining	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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=E	Continued from page 105	F 0812	Services will be auditing the dish machine logs during each meal period and the dish machine log along with the dinner cook weekly x 4 weeks then monthly x 2 months by the NHA and/or Vice President of Facilities. This plan of correction will be monitored at the monthly QAPI meeting until such time consistent substantial compliance has been met.	

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F 0812 SS=E	Continued from page 106 Based on review of select facility documentation and staff interviews, it was determined that the facility failed to utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of the forms, titled "Dish Machine Temperature Log", utilized by the kitchen, read, in part, "Keep temperature log on file for 1 year. Record Temperatures once per meal period." Review of the May 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on May 10, 14-17, 28, 30, and 31 at breakfast; May 7-18, 27, 28, 30, and 31 at lunch; and May 1-31 at dinner. June and July 2024 Dish Machine Temperature Logs failed to be provided. Review of the August 2024 Dish Machine	F 0812		

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F 0812 SS=E	Continued from page 107 Temperature Log revealed dish machine temperatures failed to be recorded on August 10 and 14 at lunch; and August 1-31 at dinner. Review of the September 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on September 1-30 at dinner. Review of the October 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on October 1-31 at dinner. Review of the November 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on November 1-30 at dinner. Review of the December 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on December 1-31 at dinner.	F 0812		

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F 0812 SS=E	Continued from page 108 Review of the January 2025 Dish Machine Temperature Log failed to reveal dish machine temperatures were logged during dinner on January 1-30; temperatures failed to be logged during all meal periods on January 31. Interview with Employee 8 (Food Service Director) on February 5, 2025, at 12:30 PM, revealed it's possible staff are not logging temperatures during dinner since management is not there to supervise. He further revealed he was unable to locate the June 2024 and July 2024 dish machine temperature logs. Interview with the Nursing Home Administrator on February 5, 2025, at 1:30 PM, revealed it is the facility's expectation that kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 201.18(b)(1) Management	F 0812		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 109 483.80(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. R2 no longer resides at the facility. R5 and R25 continues to reside at the facility. E1, E3 and E7 were educated immediately by the DON and IP Nurse on facility policy review to ensure staff implemented infection control policies to prevent the spread of infection by using PPE (personal protective equipment) and educated on how to handle potentially contaminated items to decrease the possibility for transmission of infectious disease for one of one unit treatment carts observed, along with education on Transmission-based (Isolation) precautions "Contact Precautions" to wear a gown for all interactions that may involve contact with residents or potentially contaminated areas in the residents room and/or environment. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. 3. A Root Cause Analysis was conducted and the cause was	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0880 SS=D	Continued from page 110 (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	determined that the facility staff member E3 failed to implement infection control policies to prevent the spread of infection by not using PPE (Personal Protective Equipment) in R2 care areas while providing wound care to R2, failed to follow droplet precautions to use gloves, mask, eye protection, and gown, then E3 was also observed moving an unused, unopened pack of gauze from the bedside table to R2s bed, while observed exiting the room, and returning the pack of gauze into the box in the treatment cart from where they were moved. E7 failed to perform any hand hygiene prior to entering residents R5 and R7 rooms to provide lunch on a tray, then proceeded to assist R5 with assistance of lunch. E7 failed to adhere to the droplet precautions on R5 door that revealed resident was on droplet precautions. E1 failed to enter R25's room while resident was on contact precautions and enter R25s room with lunch tray, set it up for R25 to eat then E1 exit the room and continued on taking trays to	

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F 0880 SS=D	Continued from page 111	F 0880	other residents, exiting R5 room without wearing any face protection upon entering room. and failed to handle potentially contaminated items to decrease the possibility for transmission of an infection disease from the Love and Love two units, then to one of one unit treatment carts on the Love unit. 4. A facility wide audit will be conducted by the DON, IP Nurse and Shift Supervisors by March 14, 2025 to review all residents who have the potential to be affected by this deficient practice. Re-educate all staff (including maintenance, housekeeping, dietary, administration, etc.) on donning personal protective equipment (PPE) upon room entry and discarding before exiting the room which is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. The education will also include, identifying, reporting and prevention of the Transmission-Based	

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F 0880 SS=D	Continued from page 112	F 0880	(Isolation) accepted national standards and how to use disposable of dedicated noncritical resident-care equipment between residents, the following equipment will be cleaned and disinfected by manufactures instructions with an EPA-registered disinfectant after use. The DON, IP Nurse will also educate all nursing staff on moving any unused, unopened pack of gauze from the bedside table to another resident's room, as to not exit rooms and returning the pack of gauze into the box in the treatment cart from where they were removed initially, then to and from residents' room without proper droplet precaution awareness of signage. DON and IP Nurse will continue to re-education all staff through March 14, 2025 on donning and doffing PPE to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable disease and infection.	

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F 0880 SS=D	Continued from page 113	F 0880	5. The audit will be conducted by the DON and IP Nurse at the rate of 10% weekly until 100% compliance is achieved for three consecutive audits. Then the audit will be conducted monthly x 3 months, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will be presented by the DON and IP Nurse and discussed at the monthly QAPI meeting to determine the need for further audits and or action plans.	

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F 0880 SS=D	Continued from page 114 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to ensure staff implemented infection control policies to prevent the spread of infection by using PPE (personal protective equipment) in two of four resident care areas reviewed (Love one and Love two), and failed to handle potentially contaminated items to decrease the possibility for transmission of a infectious disease for one of one unit treatment carts observed (Love unit treatment cart). Findings Include: Review of facility policy, Transmission-Based (Isolation) Precautions, last reviewed January 17, 2025, revealed that, "Contact precautions" refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Further review of this policy under the section labeled, Contact Precautions, revealed that healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all	F 0880		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0880 SS=D	Continued from page 115 interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Also, donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. Review of the aforementioned policy, revealed subsection 7-g, stated, "Use disposable or dedicated noncritical resident-care equipment ...If sharing noncritical equipment between residents, the equipment will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use." Review of Resident 2's clinical record on February 4, 2025, revealed diagnoses that included dementia (progressive, irreversible degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood	F 0880		

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CHURCH OF GOD HOME INC STATE LICENSE NUMBER: 291602	801 NORTH HANOVER STREET CARLISLE, PA 17013

(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 0880 SS=D	Continued from page 116 pressure). Review of Resident 2's clinical record revealed Resident 2 had an unstageable pressure injury (wound of the skin that has an undetermined depth due to the wound bed being covered with dead tissue or other wound debris) of the third toe on the right foot. Prior to wound treatment observation on February 5, 2025, at approximately 12:45 PM, Employee 3 (Licensed Practical Nurse) stated that Resident 2 had been diagnosed with influenza. Observation of Resident 2's room door revealed Resident 2 was on droplet precautions (use of gloves, mask, eye protection, and gown-if there is a risk of contamination e.g., coughing, aerosol treatments, splatter of infectious bodily fluids). Prior to wound treatment, Employee 3 was observed removing supplies from the Love unit treatment cart, which included individually packaged	F 0880		

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F 0880 SS=D	Continued from page 117 gauze. During wound treatment observations, Employee 3 was observed placing the treatment supplies on Resident 2's bedside table. After Employee 3 was finished with the wound treatment to Resident 2's right third toe, Employee 3 was observed moving an unused, unopened pack of gauze from the bedside table to Resident 2's bed. Employee 3 was observed retrieving the pack of gauze from Resident 2's bed, exiting the room, and returning the pack of gauze into the box in the treatment cart from where they were removed. During a staff interview directly after the observation, Employee 3 confirmed that the gauze were in the Resident's room, who was on droplet precaution for influenza and that the gauze made contact with Resident 2's table and bed. Employee 3 was observed then removing the box of gauze from the treatment cart.	F 0880		

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F 0880 SS=D	Continued from page 118 During a staff interview on February 5, 2025, at approximately 1:30 PM, Director of Nursing (DON) revealed that Employee 3 should have discarded the pack of gauze and not returned them to the treatment cart. Review of Resident 5's clinical record revealed diagnoses that included dysphagia (difficulty swallowing foods or liquids) and dementia (a brain disorder that causes a decline in cognitive function, memory, and behavior, severe enough to interfere with daily life). Observation of Resident 5 on February 3, 2025, at 12:45 PM, revealed the Resident was laying in bed in their room. There was a sign on the door that revealed Resident 5 was on droplet precautions, that further read: Everyone must clean their hands, including before entering and when leaving the room. Make sure their eyes, nose, and mouth are fully covered before room entry. Remove face protection before room exit.	F 0880		

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F 0880 SS=D	Continued from page 119 Further observation on February 3, 2025, at 12:46 PM, revealed Employee 7 enter room to provide Resident 5 their lunch tray, exit their room and enter another resident's room, then back into Resident 5's room and proceeded to assist Resident 5 in eating their lunch. Employee 7 did not perform any hand hygiene prior to entering Resident 5's room or upon exiting Resident 5's room, and did not wear any face protection upon entering their room. Review of Resident 5's current physician orders reveal an order for Droplet precautions for influenza A, with an active date of January 30, 2025. During an interview with the Nursing Home Administrator (NHA) on February 5, 2025, at 8:32 PM, confirmed that droplet precautions were not followed during the observation of Resident 5 being served lunch by Employee 7 on February 3, 2025. Review of Resident 25's clinical record revealed diagnoses that included diabetes (a chronic disease that occurs when your blood sugar levels are too	F 0880		

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F 0880 SS=D	Continued from page 120 high) and dementia (a group of diseases and illnesses that affect your thinking, memory, reasoning, personality, mood and behavior). Observation of Resident 25 on February 3, 2025, at 10:17 AM, revealed the Resident 25 sitting in her room. There was a sign on the door that revealed that the Resident was on contact precautions. Further observation at 12:19 PM, on February 3, 2025, revealed Employee 1 enter Resident 25's room to bring the Resident's lunch and set it up for Resident 26 to eat. Employee 1 then exited the room and continued taking meal trays to other residents. At no time did Employee 1 use any PPE while in Resident 25's room or even perform hand hygiene. Review of Resident 25's electronic medical record on February 3, 2025, revealed that Resident 25 was tested for scabies (a contagious skin condition caused by mites burrowing into the skin) on January 30, 2025, and the test returned positive, indicating	F 0880		

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F 0880 SS=D	Continued from page 121 that Resident 25 had scabies. Review of Resident 25's physician orders on February 3, 2025, revealed an order dated January 30, 2025, that indicated that Resident 25 was to be on contact precautions. Interview of the NHA on February 6, 2025, at 11:15 AM, revealed that she would expect employees to follow the facility policies and guidance regarding residents on contact precautions. 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 122 483.80(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. R8 and R25 continue to reside in the facility and no adverse effects related to the deficiency as cited. R8 Representative was educated on the benefits, risks and potential side effects of the vaccine and noted on clinical record. R25 Representative gave permission for the Influenza and Pneumococcal vaccine and education of the benefits, risks, or potential side effects of the vaccine is on clinical record and no adverse effects related to this practice were observed. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. A facility wide audit will be conducted by the DON and IP Nurse to provide evidence that education will be provided to Residents and/or their Representatives on the risks, benefits, or side effects of the influenza vaccine with confirmed documented on the individuals clinical record to reflect consent or refusal. All residents will be offered the pneumococcal and influenza	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0883 SS=D	Continued from page 123 (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	vaccines as part of the facility vaccination program. 3. After completion of the facility wide audit by the DON, IP Nurse and Nurse Supervisors by March 14, 2025 all licensed nurses will be educated on the policy and procedure for offering and documenting immunizations. 4. Once the vaccination program has been implemented, an audit will be conducted weekly to ensure residents have been offered the appropriate vaccines and documentation is completed by the DON and/or IP Nurse. Throughout flu season, new resident files will be audited to ensure vaccination documentation is completed and residents and representatives were educated on the benefits, risks, and potential side effects of the vaccine and noted on clinical record. Results of these audits will be discussed at the monthly QAPI meeting for three months for further review and recommendations.	

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F 0883 SS=D	Continued from page 124 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide evidence that education was provided to Residents and/or their Representatives on the risks, benefits, or side effects of the influenza vaccine for two of five residents reviewed for immunizations (Residents 8 and 25). Findings Include: Review of facility policy, titled "Influenza Vaccination" with an implementation date of April 7, 2022, and a last review date of January 17, 2025, revealed, in part, "5. Prior to the administration of the influenza vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of CDC's current vaccine information statement relative to the influenza vaccination. 6. The vaccine information statements (VIS) will, as appropriate, be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding the benefits and potential side effects of the influenza vaccine. (See	F 0883		

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F 0883 SS=D	Continued from page 125 Vaccine Information Statements Policy.) 7. Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record. 9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal." Review of Resident 8's clinical record revealed diagnoses that included hypertension (high blood pressure), diabetes (disease that occurs when your blood glucose, also called blood sugar, is too high), and severe dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 8's clinical record revealed that	F 0883		

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F 0883 SS=D	Continued from page 126 Resident 8's Representative refused the flu and RSV vaccination on September 4, 2024. Further review of Resident 8's clinical record revealed no evidence that Resident 8's Representative was educated on the benefits, risks, or potential side effects of the vaccine. Review of Resident 25's clinical record revealed diagnoses that included diabetes, hypertension, and protein-calorie malnutrition (nutritional status in reduced availability of nutrients leads to changes in body composition and function). Review of Resident 25's clinical record revealed that the Resident last received an influenza vaccine on September 27, 2024. Further review of Resident 25's clinical record revealed no evidence that Resident 25 or Resident 25's Representative were educated on the benefits, risks, and potential side effects of the vaccine. During a staff interview with Employee 10 (facility Infection Preventionist) on February 4, 2025, at	F 0883		

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F 0883 SS=D	Continued from page 127 approximately 1:40 PM, Employee 10 revealed that the facility does not utilize influenza or pneumococcal vaccine consent or declination forms. Employee 10 indicated that they speak with Residents and/or their Representatives, distribute the appropriate Vaccine Information Statement to the Resident and/or their Representative and that they then complete a note in the Resident's medical record regarding consent or refusal and education provided. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on February 6, 2025, at 2:09 PM, the NHA confirmed that influenza vaccine education should have been provided to Residents 8 and 25 and/or their Representative and that documentation should have reflected such. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(2)(5) Nursing services	F 0883		

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F 0887 SS=D		F 0887		

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F 0887 SS=D	Continued from page 129 483.80(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. R8 and R25 continue to reside in the facility and no adverse effects related to the deficiency as cited. R8 Representative was educated on the benefits, risks and potential side effects of the Covid-19 vaccine and noted on clinical record as refusal, declination documented. R25 last received the COVID-19 booster vaccine on October 20, 2024 and representative was educated on the benefits, risks and potential side effects of the Covid-19 vaccine, no adverse effects related to this practice were observed. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. A facility wide audit will be conducted by the DON and IP Nurse to provide evidence that education will be provided to Residents and/or their Representatives on the risks, benefits, or side effects of the Covid-19 vaccine with confirmed documented on the individuals clinical record to reflect consent or refusal. All residents will be offered	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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F 0887 SS=D	Continued from page 130 (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	the Covid-19 vaccine and or booster as part of the facility vaccination program. 3. After completion of the facility wide audit by the DON, IP Nurse and Nurse Supervisors by March 14, 2025 all licensed nurses will be educated on the policy and procedure for offering and documenting immunizations, including the Covid-19. 4. Once the vaccination program has been implemented, an audit will be conducted weekly to ensure residents have been offered the appropriate Covid-19 vaccines and documentation is completed by the DON and/or IP Nurse. Throughout the uptick of the Covid-19 season, new resident files will be audited to ensure the Covid-19 vaccination documentation is completed and residents and representatives were educated on the benefits, risks, and potential side effects of the Covid-19 vaccine and noted on clinical record. Results of these audits will be	

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F 0887 SS=D	Continued from page 131	F 0887	discussed at the monthly QAPI meeting for three months for further review and	

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F 0887 SS=D	Continued from page 132 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide evidence that education was provided to Residents and/or their Representatives on the risks, benefits, or side effects of the COVID-19 vaccine for two of five residents reviewed for immunizations (Residents 8 and 25). Findings Include: Review of facility policy, titled "COVID-19 Vaccination" with a last revised date of June 19, 2023, and a last review date of January 17, 2025, revealed "26. The resident's medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal." Review of Resident 8's clinical record revealed	F 0887		

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	395784	A. BLDG: __00_____ B. WING: _____	02/06/2025

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F 0887 SS=D	Continued from page 133 diagnoses that included hypertension (high blood pressure), diabetes (disease that occurs when your blood glucose, also called blood sugar, is too high), and severe dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 8's clinical record revealed that Resident 8's Representative refused the COVID-19 vaccination on September 4, 2024. Further review of Resident 8's clinical record revealed no evidence that Resident 8's Representative was educated on the benefits, risks, or potential side effects of the vaccine. Review of Resident 25's clinical record revealed diagnoses that included diabetes, hypertension, and protein-calorie malnutrition (nutritional status in reduced availability of nutrients leads to changes in body composition and function). Review of Resident 25's clinical record revealed that	F 0887		

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F 0887 SS=D	Continued from page 134 the Resident last received a COVID-19 booster vaccine on October 20, 2024. Further review of Resident 25's clinical record revealed no evidence that Resident 25 or Resident 25's Representative were educated on the benefits, risks, and potential side effects of the vaccine. During a staff interview with Employee 10 (facility Infection Preventionist) on February 4, 2025, at approximately 1:40 PM, Employee 10 revealed that the facility does not utilize COVID vaccine consent or declination forms. Employee 10 indicated that they speak with Residents and/or their Representatives, distribute the appropriate Vaccine Information Statement to the Resident and/or their Representative and that they then complete a note in the Resident's medical record regarding consent or refusal and education provided. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on February 6, 2025, at 2:09 PM, the NHA confirmed that COVID vaccine education should have been	F 0887		

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F 0887 SS=D	Continued from page 135 provided to Residents 8 and 25 and/or their Representative and that documentation should have reflected such. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(2)(5) Nursing services	F 0887		

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P 1020		P 1020		

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

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P 1020	Continued from page 1 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. The facility was evaluated on the review of the facilities' Infection control Committee attendance records to ensure this standard of operation set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents were being followed by all attendees present on a monthly basis, the Infection Control Committee meeting includes, Medical Staff, Nursing Staff, Administration, laboratory personnel, physical plant personnel, Safety Officer and a community member, attendance will be mandated accordingly and deficiency corrected by March 14, 2025. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. The Infection Control Committee will continue to meet monthly to ensure an Infection Control plan as stated is developed and implemented that include, multidisciplinary committee	Completion Date: **03/14/2025** Status: **APPROVED** Date: **02/26/2025**

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P 1020	Continued from page 2	P 1020	including representatives from each of the specific health care facility to include Medical Staff, Administration, Nursing Staff, Patient Safety Officer, Physical Plant Personnel, community member, laboratory personnel, pharmacy staff and infection control team members. 3. All Infection Control Committee members will be re-educated on monthly mandated attendance to ensure three of nine required multidisciplinary members are present to meet compliance standards and regulation by March 14, 2025. The NHA will invite the committee a month before the next meeting and send reminders out a week prior of the scheduled meeting date to ensure 100% participation is achieved. 4. The NHA will conduct monthly audits X 3 months to ensure attendance of members, if 100% compliance is achieved/maintained, the deficiency will be considered resolved. Results of the audits will	

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P 1020	Continued from page 3	P 1020	be presented by the NHA and discussed at the monthly QAPI meeting to determine the need for further audits and or action plans.	

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P 1020	Continued from page 4 Based on staff interview and review of the facility's Infection Control Committee attendance records, the facility failed to ensure that three of nine required multidisciplinary members were present at the Infection Control Committee meeting (laboratory personnel, physical plant personnel, and a community member). Findings include: Review of Act 52 (The Act of March 20, 2002, P.L.154, No. 13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, Chapter 4, Section 403(1) Infection Control plan stated, "A health care facility... shall develop and implement an internal infection control plan that shall include...a multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility." A review of the applicable members included Medical Staff, Administration, Nursing Staff, Patient Safety Officer, Physical Plant Personnel, community	P 1020		

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P 1020	Continued from page 5 member, laboratory personnel, pharmacy staff, and infection control team members. Review of the facility provided attendee signature pages for their monthly Quality Assurance Performance Improvement (QAPI) and Infection Control Meeting revealed in Quarter 2 April/May/June 2024, that no Physical Plant Personnel or laboratory personnel had attended any of the monthly meetings. Review of the facility provided attendee signature pages for their monthly Quality Assurance Performance Improvement (QAPI) and Infection Control Meeting revealed in Quarter 3 July/August/September 2024, that no Physical Plant Personnel, community member, or laboratory personnel had attended any of the monthly meetings. Review of the facility provided attendee signature pages for their monthly Quality Assurance Performance Improvement (QAPI) and Infection Control Meeting revealed in Quarter 4	P 1020		

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P 1020	Continued from page 6 October/November/December 2024, that no Physical Plant Personnel, community member, or laboratory personnel had attended any of the monthly meetings. During a staff interview with the Nursing Home Administrator on February 5, 2025, at 1:29 PM, she indicated that the facility has the meetings monthly and they try to get all required attendees to attend at least one meeting per quarter. She confirmed that all required members failed to attend at least one meeting per quarter. She further indicated that Physical Plant Personnel had never attended because the corporate office indicated that they did not need to attend.	P 1020		

Certified End Page

CHURCH OF GOD HOME INC

STATE LICENSE NUMBER: 291602

SURVEY EXIT DATE: 02/06/2025

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